

**AN EXPLORATION OF THE SOCIAL AND CULTURAL FACTORS
WHICH INFLUENCE INDIAN PUNJABI MEN'S HEALTH BELIEFS
AND RISK PERCEPTIONS OF TYPE 2 DIABETES**

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ABSTRACT

Type 2 Diabetes (T2D) affects over 246 million people worldwide. South Asians are the largest group affected and have the fastest growing prevalence. South Asians have been identified as at risk due to biomedical dispositions including central adiposity and insulin resistance. Lifestyle factors are also associated with T2D. However, the majority of research area tends to homogenise south Asians, consequently overlooking some of the subtle cultural differences between sub groups. As a result, British Indian Punjabi men have been neglected from research, despite being one of the largest groups at risk. This qualitative study examined the social and cultural factors which influence Indian Punjabi men's health beliefs and risk perceptions of T2D. Twenty-four interviews were carried out with Indian Punjabi men from first and second generations. The data was analysed using a thematic analysis approach. The findings revealed the cultural significance associated with hospitality and drinking, which emerged as important socio-cultural practices. The findings also demonstrated generational differences in how the men perceived their risk of T2D in either individual or collective terms. The findings of this research study have the potential to make an important contribution to T2D care by highlighting changes to future care strategies.

DEDICATION

This thesis is dedicated to my parents, Baldev and Shakuntala and to the legacy of my grandparents: Papa-ji Beeru Ram, Bibi-ji Bhago, Nana-ji Dault Ram and Nani-ji Karmi.

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CHAPTER ONE: INTRODUCTION

The aim of this thesis is to investigate the social and cultural factors which influence Indian Punjabi men's health beliefs and risk perceptions of Type 2 Diabetes Mellitus (T2D). With the prevalence of T2D expected to rise to epidemic proportions amongst south Asians, there is a need for research to identify the factors which influence health beliefs and risk perceptions within individual south Asian groups. This research study aims to address this gap in knowledge by exploring Indian Punjabi men's health beliefs and risk perceptions of T2D.

T2D is a metabolic disorder and develops when the body is unable to produce enough insulin, or when the insulin that is produced does not work efficiently, which is also known as insulin resistance. The onset of T2D is associated with a number of different risk factors including hypertension, obesity and ethnicity (Diabetes UK, 2012). If left untreated or poorly managed, T2D can lead to the development of serious complications such as heart disease, kidney disease and stroke (Diabetes UK, 2012). However, T2D can be managed through lifestyle modifications such as increased physical activity and dietary changes (Diabetes UK, 2012).

In the UK, 2.9 million people have been diagnosed with diabetes (QOF, 2011). In England, the prevalence of diabetes was 5.5% in 2011, with over two million people living with the condition (QOF, 2011).

In the UK, T2D is a major health issue for people of south Asian origin, who are six times more likely to develop diabetes than the general population (NFS, 2001).

South Asians' increased susceptibility of T2D is strongly associated with biomedical

risk factors, including increased genetic susceptibility of insulin resistance and abdominal obesity, as well as lifestyle factors such as reduced physical activity, smoking, and diet (McKeigue et al., 1991; Barnett et al., 2006).

The growing rate of south Asians with T2D in the UK is a pressing health issue for the National Health Service (NHS). With the number of people with T2D expected to rise, the financial burden of T2D care on the NHS is also expected to increase. It has been reported that £8.8 billion has been spent on T2D care in 2010/2011 (Hex et al, 2012).

The 'diabetes epidemic' has resulted in renewed government focus on management and prevention of T2D in the UK (Zimmet et al., 2001; Wild et al, 2004; NICE, 2009; 2011). This has been reflected in the Diabetes National Service Framework (NSF) published in 2001, which was the first set of national standards aimed at improving health outcomes for people with diabetes in England (NSF, 2001). The NSF called for a patient-centred approach to diabetes care, and highlighted the importance of self-management. The National Institute of Clinical Excellence (NICE) has developed evidence based national clinical guidelines for T2D which support the current NSF (NICE, 2009, 2011). More recently, public health guidelines have been developed on the prevention of T2D amongst high-risk groups and the prevention of 'pre-diabetes' among adults aged 18-74 (NICE, 2011). Recommendations include the implementation of local and national action to promote health messages, and the importance of culturally appropriate interventions for ethnic minority groups. This is due to the fact that culture has been identified as an important factor which influences health behaviours among 'at risk' groups, including self-management techniques (Kleinman, 1980; Helman, 2001).

Currently, there is a lack of evidence about successful interventions amongst south Asian groups (Bhopal, 2006). This is largely due to the underrepresentation of south Asians in intervention research programmes compared to the European population (Mason et al., 2003; Webb et al., 2011). This has meant that some interventions are not culturally suited towards the needs of south Asians (Hawthorne et al., 2010).

However, culture is not universal across south Asians and cultural diversity produces differences in lifestyle choices and health beliefs (Bhopal et al., 1991; Senior and Bhopal, 1994; Bhopal, 2004). The literature exploring cultural influences on self-management behaviours among the south Asian population is ambiguous as there are few studies that have explored the cultural differences between individual groups. This is largely to do with the fact that the south Asian population continue to be underrepresented and incorrectly described as a homogenous population in the literature (Nazroo, 1998; Bhopal, 2002). However, south Asians are heterogeneous in a number of ways. They are diverse in their heritage, and originate from different parts of the Indian sub-continent, including India, Pakistan, Bangladesh and Sri Lanka. They are also diverse in what they eat, the religion they follow, the language they speak, and the customs they practise (Ahmed and Lemkau, 2000).

This has led to the oversimplification of the use of the term 'culture', which is commonly used to describe the health related practices of a widely diverse group. This broad-brush, and somewhat misguided, approach has led to a lack of exploration into the identification of the cultural nuances and subtle differences that exist between south Asian subgroups, which have become blurred and indistinct. This has led to some research contributing to the current misconception that all south Asians are unhealthy and suffer from chronic disease in the same way (Senior and

Bhopal, 1994), whereas evidence has shown this to be to the contrary as risk of diseases are not uniform across all south Asian groups (Williams, et al., 1994; Balarajan, 1996; Bhopal et al., 1999). It is important to acknowledge that some studies have focused on individual south Asian groups; however these tend to be heavily focused on Pakistani and Bangladeshi populations (Kelleher and Islam, 1994; Greenhalgh et al., 1998; Rhodes et al., 2003). These groups share some similar demographic characteristics in that they tend to come from lower socio-economic backgrounds (Bhopal et al., 1999; HSE, 2004) and are often marginalised from health-care services (Smaje and Le Grand, 1997; Rhodes et al., 2003), characteristics which have made them more commonly researched in health research as they are multiply disadvantaged.

However, Indian Punjabis are currently under-represented in T2D research in the UK. This is particularly surprising since evidence shows that Indians face their own risks associated with physical inactivity, alcohol consumption and insulin resistance (Bhatti et al., 2007; Kokiwar et al., 2007). In addition, Indians are also disadvantaged in terms of their genetic predisposition, which means they have an increased susceptibility to T2D (Williams et al., 1993; Radha and Mohan, 2007).

Indians are also the largest south Asian group living in England and Wales (Census, 2011), and include people who originate from a number of Indian states including the Gujarat, Goa and Bangalore. The Indian Punjabi population are a unique group, because unlike other south Asian groups, they are not strongly influenced by their religion, but by their cultural identity (Ballard, 2000; Nayar, 2004). The influence of Punjabi culture on health beliefs and practices amongst those living in the UK has not been fully developed. However, studies conducted in Canada are beginning to

uncover the links between Punjabi culture and lifestyle practices. For example, Oliffe et al. (2010) found that Indian Punjabi men's masculine ideals are rooted in traditional cultures and influence the consumption of specific foods.

The aim of this research study is to address a gap in diabetes health research by highlighting the social and cultural factors that influence the health beliefs of one of the largest south Asian groups living in England today. Furthermore, little research has been done into how this group understand risks associated with T2D.

Studies which have explored risk perception of T2D amongst the south Asian population have found them to be influenced by a plethora of factors, including knowledge of disease, perceptions of its severity and socio-cultural practices related to diet and religion (Kelleher and Islam, 1996; Greenhalgh et al., 1998; Naeem, 2003; Lawton, 2008). In addition, evidence has shown that there is a gulf between lay and professional perception of risk, which can lead to inconsistencies in care (Bickerstaff, 2004). Whilst it is acknowledged that people's risk perception may not signify behaviour change (Marteau and Lerman, 2001), there is a need to understand the complexities of risk perception in order to inform and improve effective health promotion and risk communication.

If interventions targeting 'south Asians' are to be successful, they need to be attentive to their different lifestyles, customs and attitudes. Distinguishing between south Asian groups in T2D research has the potential to reveal these differences. Clearly identifying south Asian groups may highlight the different cultural barriers they face, and reduce stereotyping and generalisations made across broad groups. Researchers who currently generalise 'south Asians' should recognise the

implications the term has for the validity of their descriptions of cultural differences, socio-economic patterns and demographic markers. All of which contribute to the ambiguity surrounding knowledge about the health practices of south Asians living in the UK.

This thesis focuses on exploring the experiences of Indian Punjabis, who are those who have either migrated or have heritage to the Indian Punjab (Singh, 2003). It is important to clarify that all references to the 'Punjab' in this thesis will be in relation to the Indian Punjab, as the Punjab also has a Pakistani province. After the partition of India in 1947, the Punjab became divided between India and Pakistan, and the Indian Punjab later became established as a state in 1966. Pakistani Punjabis have different characteristics in terms of culture and religion, which makes them a different population entirely (Singh, 2003).

1.0 Research design

This research is guided by Social Constructionism (SC), which is characterised by the theory that social phenomena are created and sustained by human practices (Berger and Luckmann, 1966). A full discussion about the application of SC in this study is detailed in Chapter Four. SC was selected as the theoretical lens for this study as it is concerned with exploring individual life experiences, and how knowledge and realities of health beliefs have been created. Therefore, SC can be used to reveal how individual life experiences have become situated within a specific cultural context. The emphasis of the individual life experience is paramount in this study as a means to understand how knowledge and realities of health beliefs are

created. Therefore, investigating the life experience is a means of accessing the ways in which individuals create understandings of their world to reveal the social constructions influencing health beliefs and perceptions.

This study adopts the social constructionist framework to consider how knowledge and perceptions of health have come to be created through interactions with others and the community under investigation.

1.1 Methods

It was important to select a set of methods that reflected the theoretical approach of SC. Therefore, a narrative inquiry approach was adopted to access the men's interpretation of health experiences through narratives and storytelling. This method has been identified as reliable in exploring the experiences and meanings of health amongst individuals, including beliefs about chronic illness (Polkinghorne, 1995; Bury, 2001)

Twenty four interviews were conducted with first and second generation Indian Punjabi men who originated from the West Midlands. Snowball sampling was utilised as the recruitment method. The data was analysed using Riessman's (2003) 'thematic analysis'. This method was selected as it can reveal conceptual themes which emerge naturally from the men's narratives. Themes were then organised and grouped together to find similarities and differences across the data.

1.2 Aim

The aim of this thesis is to present the investigation into Indian Punjabi men's health beliefs and perceptions of risks related to T2D, to develop greater understanding of the relationship between health beliefs and health behaviour in order to inform educational and lifestyle interventions for this group.

1.3 Objectives

- To identify and explore the specific cultural and social practices which shape Indian Punjabi men's health beliefs.
- To explore how the risk of T2D is perceived amongst Indian Punjabi men.

1.4 Outline of the thesis

Chapter Two sets the scene of this research study by expanding on the main components of the research question. This includes an overview of the epidemiology and the prevalence rates of T2D within the south Asian community living in the UK. This chapter also explores the population characteristics of Indian Punjabis, including their migratory path from India to the UK. The chapter closes with a discussion of the concept of 'risk' and the main theoretical concepts used in the exploration of risk perception. Chapter Three provides an overview of the literature focusing on the health beliefs and health practices of south Asians living in the UK. The review aims to explore the social and cultural factors which influence health beliefs and health practices associated with T2D, to reveal the heterogeneities which exist between

different south Asian subgroups. Chapter Four describes the methodological approach used in this research study and the methods selected to collect data. This chapter also includes a reflexive account of the researcher's experience conducting the research, and concludes with an overview of the analysis of the data. Chapter Five presents the empirical findings from the interviews with the Indian Punjabi men. The findings are organised into themes, which describe the topics which were discussed. Finally, Chapter Six reviews the main findings presented in the study in light of the two objectives of the study. This chapter also attends to the limitations of the study, the implications the findings have for policy, practice and research and concludes with recommendations for further research.

CHAPTER TWO: RESEARCH CONTEXT

2.0 Introduction

This chapter provides a background to the context of this research, outlining some of the main components of the research question and comprises of two parts:

Part One begins with a description of T2D, epidemiology, complications and the disproportionate prevalence amongst south Asians living in the UK. This section also discusses the implications of the use of the term 'south Asian' to describe a heterogeneous population who have varying social and cultural beliefs.

This chapter will then go on to describe the population of Indian Punjabis living in the UK and their migratory path to the UK. This includes an acknowledgment of the creation of 'Diasporas', which describes how migrants have come to be linked to their homeland via attachments and connections created in new locations (Vertovec, 1999). The section concludes with a brief overview of the geographical origin of the majority of British Indian Punjabis': the Punjab, as well as a brief history of the religion of its dwellers: Sikhism.

Part Two focuses on the concept of risk and risk perception. Advances in scientific knowledge and technology have increased awareness of the nature of risks, hazards and dangers present in everyday life (Beck, 1992). From an epidemiological perspective, risk is an objective fact (Macaden, 2007). However, lay people do not perceive risk in the same way as they apply meaning within the context of the world in which they live (Lupton, 2003). Alongside this, people infer personal meanings from risk information which inform their decisions and actions (Shore, 1996). Studies

exploring these phenomena are addressed under risk perception, which is primarily concerned with identifying how risk is understood and managed by individuals.

It is known that there is an interplay between professional and lay knowledge in the context of chronic disease risk (Bury, 1982). This has led to increased interest into the exploration of risk perception of those at increased risk of T2D, such as south Asians, as it is known to influence self-management behaviours (Macaden and Clarke, 2006).

This section will conclude with an exploration into the definition of risk and the three dominant approaches that theorise risk perception: the biomedical model, the psychometric approach, and cultural theory.

2.1 Part One

2.1.1 Type 2 Diabetes

T2D is a progressive long-term metabolic disorder which is characterised by high blood glucose and is the most common form of diabetes. T2D occurs when the body fails to produce enough insulin or the body's cells do not react to insulin, otherwise known as insulin resistance. Insulin insensitivity is commonly caused by overeating and inactivity and is also associated with hypertension (NICE, 2008). T2D is diagnosed in adults by a glycated haemoglobin (HbA1c) level of 6.5% or above (WHO, 2011). T2D is associated with increased cardiovascular risk such as coronary heart disease (NICE, 2008). Long-term levels of insulin deficiency are also

associated with microvascular complications, such as eye damage (retinopathy) and kidney disease (nephropathy) (Kohner, 1993; Bakris and Stein, 1993).

The prevalence of T2D is associated with a number of factors related to genetic disposition, lifestyle and environmental factors (McCarthy and Menzel, 2001; Van Dam, 2003; Parillo and Riccardi, 2004). The estimated global prevalence of diabetes in 2013 was 382 million, and is predicted to rise to 592 million people by 2035 (IDF, 2013). In the UK, there are 2.9 million people diagnosed with diabetes (QOF, 2011). Table 1 shows the prevalence of diabetes in the adult population across the UK in 2011:

Table 1. Prevalence of diabetes in adults in the UK in 2011

Country	Prevalence	Number of people
England	5.5%	2,455,937
Northern Ireland	3.8%	72,693
Scotland	4.3%	223,494
Wales	5.0%	160,533

(QOF, 2011)

The prevalence data has been sourced from the Quality and Outcomes Framework (QOF). QOF was introduced in 2004 and provides financial incentives to general practices for the provision of high quality care. As part of QOF, general practices register the number of people with diabetes which generate prevalence figures. One advantage of using QOF data is that prevalence figures can be applied to current populations to provide an estimate of the number of people with diabetes. However, these figures should be treated with caution as they are indications of 'doctor diagnosed' diabetes. Therefore, the figures may not be fully representative of those

who do not receive health care from general practice, including south Asians. For example, evidence has shown that some groups of south Asians may hide their condition from others due to fear of community knowledge of family illness, which can reduce adherence to treatment (Singh et al, 2012).

With the prevalence of T2D predicted to rise, the financial burden on the NHS is expected to increase. In 2011, the NHS spend on diabetes was almost £10 billion, and is projected to rise to £16.9 billion over the next twenty-five years (Hex et al., 2012).

2.1.2 Prevalence of T2D in the Indian population

In the UK, T2D is most common amongst the older south Asian population, with prevalence being six times higher than the national average (NSF, 2001). However, evidence has shown that within the south Asian population, T2D is particularly prevalent within the Indian population. Statistics from the HSE (2004) show that Indians had the highest prevalence of doctor-diagnosed diabetes in England, compared to their south Asian counterparts (HSE, 2004) (see Table 2):

Minority ethnic group	Men	Women
Bangladeshi	8.2%	5.2%
Black African	5%	2.1%
Black Caribbean	10%	8.4%
Chinese	3.8%	3.3%
Indian	10.1%	5.9%
Irish	3.6%	2.3%
Pakistani	7.3%	8.6%
General population	4.3%	3.4%

Table 2. Doctor diagnosed diabetes

(HSE, 2004)

Epidemiological studies provide biomedical evidence as to why the Indian population appear to be at increased susceptibility of T2D due to increased insulin resistance which has been associated with centrally-distributed obesity (Sharpe et al., 1987; McKeigue et al., 1992) and excess body fat and abdominal adiposity (Misra et al., 2004). However, the excessive prevalence of insulin resistance amongst Indians has also been observed despite the absence of excessive obesity (Abate et al, 2003). Abate et al. (2003) discuss how the Indian population appear to be characterised by a genetic tendency towards truncal accumulation of fat or abdominal fat distribution, which some studies have shown to be linked to excessive insulin resistance amongst Indians (Banerji et al., 1999; Raji et al., 2001). Chandalia et al. (1999) explored the role of adiposity and fat distribution in the excessive insulin resistance of Indians by performing biometric tests including hydro-densityometry and skinfolds measurements in twenty-one healthy Indian men and twenty-three Caucasian men of similar age and body fat content. Their study showed that the glucose disposal rate during hyperinsulinemia was lower in the Indians than in the Caucasians, and despite similar body fat content, the Indians had higher truncal adiposity than the Caucasians. Even after adjusting for total body fat and truncal skinfolds thickness, Indians still had excessive insulin resistance compared to the Caucasians (Chandalia et al, 1999). Their study suggests that neither obesity nor fat distribution explains the excessive insulin resistance and T2D amongst Indians. Instead, excessive insulin resistance amongst Indians may be due to a metabolic defect which may account for their excessive morbidity and mortality from T2D (Chandalia et al, 1999). These findings, along with other evidence (Radha and Mohan, 2007), suggest that the

Indian population may have a genetic predisposition which increases their risk of T2D.

2.1.3 Summary

The prevalence of T2D amongst south Asians living in the UK has contributed to the increase in health research exploring south Asians and self-management and diabetes care, which has particularly focused on: health beliefs, socio-cultural factors which influence lifestyle, food and religious practices (Khajuria et al., 1992; Greenhalgh et al., 1998; Chowdhury et al., 2000; Naeem, 2003; Lawton et al., 2006; Fleming et al., 2007).

While these studies have made important contributions to knowledge about the lifestyle practices of south Asians, there still remains some ambiguity around the practices of specific south Asian subgroups. The following describes some of the shortcomings in the literature, which tends to describe south Asians as a homogenous population, consequently ignoring the heterogeneous characteristics of different subgroups.

2.1.4 South Asians; A heterogeneous population

Ethnicity describes a group of people who belong to a group based on shared characteristics, including ancestral and cultural traditions (Kelleher, 1996). Yet, there continues to be discrepancies and inconsistent use of the term 'south Asian' in health research literature (Bhopal, 2002). For example, the majority of studies in this area tend to employ the term 'south Asian' to describe a heterogeneous population by grouping together those who originate from the south Asian subcontinent. This has

been particularly evident in studies exploring the health practices of 'south Asian women' (Sriskantharajah and Kai, 2006; Grewal et al., 2005). The use of the term 'south Asian' in this way is problematic for the identification of those who belong to different south Asian subgroups. The main implication of this is how the cultural differences between subgroups become indistinguishable, which may affect the appropriateness of preventative strategies and interventions for these groups. For example, in their qualitative study, Sriskantharajah and Kai (2006) explored the influences on attitudes towards physical activity among south Asian women with coronary heart disease and diabetes to inform prevention strategies. Their findings offered insights into a range of themes including; perceived harm of physical activity, weight loss to perception of exercise (Sriskantharajah and Kai, 2006). Whilst the study claimed to explore the factors which may hinder and promote physical activity among south Asian women, the findings are limited in how they failed to address sub-group differences within the sample. For example, it is known that not all south Asian women face the same barriers to physical activity equally due to differences in cultural and religious restrictions (Khanam and Costarelli, 2008). By failing to critically examine the sub-group heterogeneities, their findings have limited use for the improvement of culturally appropriate interventions for this group. In another example, Grewal et al. (2005) conducted a qualitative study exploring the influence of family members on immigrant south Asian women's health and health seeking behaviours. Their findings explored number of themes including; patterns of influence based on family relationship and the influence of family response to women's health concerns (Grewal et al., 2005). Similarly to Sriskantharajah and Kai's (2006) study, despite claiming to have included a diverse ethnic sample, their findings failed to

include any exploration into sub-group heterogeneities. As a result, the findings were generalised as applying across all 'south Asian' women. The limitation of this approach is that it ignores the intricacies which occur within sub-groups, which reduces the relevance of its findings for improved health care for south Asians.

Bhopal et al. (2004) have addressed the problems associated with using the term 'south Asian' to describe a population who originate from different parts of south Asia, which includes those who are Indian, Pakistani, Bangladeshi, Gujarati and Sri Lankan (Bhopal et al., 1991; Bhopal, 2004). However, while not all south Asians can be neatly defined, identity should be recognised as fluid, complex and socially created (Bhopal, 1991). Nevertheless, health research focused on south Asians needs to make distinctions between Indians, Pakistanis, Bangladeshis and Sri Lankans in order to eliminate the misconception that all ethnic minorities are unhealthy and/or suffer in the same way. For example, studies have shown that the risk of diseases is not uniform across the south Asian population (Williams, et al., 1994; Balarajan, R. 1996; Bhopal et al., 1999). In addition, there are differences in cultural and social practices across the south Asian groups, as social norms and practices vary and produce differences in lifestyle choices and health beliefs (Bhopal et al., 1991; Senior and Bhopal, 1994; Bhopal, 2004). Clearly distinguishing between south Asian subgroups would be beneficial in uncovering cultural differences which will enhance knowledge about the health practices of different south Asian groups. It can be argued that the current homogenisation of south Asians living in the UK is contributing to the growing ambiguity surrounding their health practices.

It is important to recognise that not all health research homogenises south Asians. Studies have explored the health practices of subgroups such as Gujarati, Bangladeshi and Pakistani populations (Hawthorne et al., 1999; Jobanputra and Furnam, 2005; Rozario, 2009). By clearly identifying the ethnic grouping of their samples, these studies have been able to clearly draw on the specific cultural barriers these groups face in their care and prevention of T2D.

For example, Hawthorne et al. (1999) conducted a qualitative study exploring the factors which influence knowledge and self-management of diabetes amongst a Pakistani population. The study demonstrated that whilst the management and knowledge of diabetes was particularly low, the findings also identified the specific cultural barriers this group face. This included illiteracy for Pakistani women, due to cultural restrictions imposed on them not to pursue education or language learning (Hawthorne et al, 1999).

Similarly, Jobanputra and Furnam's (2005) study highlighted the impact of the cultural influences on the health and illness beliefs amongst British Gujarati Indian immigrants. Whilst this was a comparative study, the findings showed the extent to which ill health is attributed to supernatural factors for the Indian immigrants which was considered to be part of their cultural identity (Jobanputra and Furnam, 2005). This focused investigation into one group has the potential to specifically inform health interventions targeting this group to be sensitive of the beliefs held by Indian Gujarati immigrant groups which would make them more culturally appropriate.

In another example, Rozario's (2009) reflection on anthropological work exploring illness among British Bangladeshi Muslims focuses on the role of religion in the explanation of illness and cure amongst this group. The paper highlights the influence of Allah as the decider in illness and healing (Rozario, 2009). These findings have important implications for informing HCPs of this group's specific religious beliefs which may deter followers from biomedical routes of treatment.

Elsewhere, Canadian studies focused on the Canadian Indian Punjabi population have explored the dietary practices of Punjabi Sikh immigrant men (Olliffe et al., 2010; Chapman et al., 2010), Sikh health beliefs (Labun and Emblen, 2007) and Sikh men's perspectives of managing coronary heart disease risk (Bedi et al., 2009).

However, minimal research has focused on the health experiences of Indian Punjabis living in the UK. The underrepresentation of this group in the health research literature, along with the growing evidence highlighting this group's increased epidemiological risk of T2D points to the need for further work to be conducted into the health experiences of this 'at risk' population. This study aims to address this gap by illuminating Indian Punjabi men's health beliefs and risk perceptions of T2D across two generations.

2.1.5 A focus on Indian Punjabi men

This research study is focused on the health beliefs and perceptions of risk of one south Asian ethnic minority group: Indian Punjabi men. This population was selected

primarily due to the fact that this group are under-represented within British diabetes health research, despite them being the largest south Asian group living in England and Wales (Census, 2011).

In addition to this, statistical information collected about this group's lifestyle practices alludes to some unique trends related to physical activity levels and alcohol consumption. For example, the Household Survey for England (HSE, 2004) showed that the Indian population have the lowest physical activity levels with 14% of the population meeting the recommended guidelines for physical activity, compared to 30% of Pakistanis and 45% of Bangladeshis (HSE, 2004). The General Household Survey (GHS) combined drinking data from the years 2001 to 2005 to reveal drinking habits by ethnic group. The results showed that Indian men were the highest population of alcohol drinkers compared to Pakistani and Bangladeshi men (GHS, 2005). Combined data from the GHS between the years 2001 to 2005 revealed the prevalence of cigarette smoking among ethnicity minority groups. It showed that Indian men are reported to be the lowest group for smoking compared to other British Bangladeshi males (GHS, 2005).

These trends go some way to revealing the complex picture of the health and lifestyle practices of this group. Some studies have begun to explore the socio-cultural factors behind these patterns, and found links between the social meaning of food and its consumption in social settings (Bush et al., 1998; Greenhalgh et al., 1998; White and Kokotsaki, 2004; Grace et al., 2008). Relationships also exist between cultural identity construction and the consumption of alcohol amongst Indian Punjabi men (Olliffe et al., 2010). While the literature shows the tentative links between socio-cultural factors and health practices amongst the Indian Punjabi population, the

specific factors which influence attitudes to T2D and risk perceptions have not been fully investigated in the literature. This will be explored in more detail in Chapter Three.

2.1.6 Summary

Bhopal's (2004) discussion of the problematic use of the term 'south Asian' in health research is still relevant today as there is continued inconsistent use of the term to describe people with origins in the Indian subcontinent. It is important to note that the term 'Indian' is not sufficient in accurately identifying Indian Punjabis as it can also describe those from other regions of India such as the Gujarat (Gujarati Indians) or Goa (Goan Indians). 'Indian Punjabi' refers to those from or who have heritage from the Indian Punjab, located in North Western India. The following section summarises the migration path typical of many Indian Punjabis and other south Asians from their homeland in the Indian subcontinent to the UK.

2.1.7 Migration of South Asians

Since the nineteenth century, vast numbers of south Asians have migrated throughout the world. This mass migration occurred during two periods: the first was characterised by imperialism during colonial times. During this time large numbers of south Asians were taken to various colonial countries worldwide where they worked as labourers. The second period took place during the early twentieth century, during which south Asians travelled to western countries freely and took occupation in skilled, unskilled and professional jobs (Clarke et al., 1990). This period of migration

was shaped by the outbreak of the First World War in 1914. As British male workers left to serve in the war, shortages in industrial labour emerged. As a result, migrants already living in the country found new opportunities in employment (Ballard, 2002). The growth of the British south Asian population increased as a result of chain migration due to the post-war economic boom. The peak of immigration of those from the Indian subcontinent to the UK occurred during the 1960s and 1970s (Landman and Cruickshank, 2001).

Ballard (2002) identified the common characteristics of the migrant British south Asian population in that they were of rural origin, either farmers or craftsmen by trade, and arrived without any professional qualifications (Ballard, 2002). Despite their shared socio-economic backgrounds, each of the south Asian subgroups followed different courses in relation to upward mobility. The Gujarati population who migrated to the UK via East Africa succeeded in upward mobility, a trend which was replicated by Indian Punjabi Sikhs from the Punjab (Ballard, 2002).

The settlement of south Asian immigrants in the UK during the 1960s was largely determined by the availability of jobs and accommodation in areas of south London and regions of the West Midlands, particularly Wolverhampton, Coventry and Birmingham (Hamlett et al., 2008). Many from the older generation found success in business enterprises such as corner shops and manufacturing. Despite the relative success of the Gujarati and Punjabi populations, those from Mirpuri and Sylhet regions were slower in gaining the same socio-economic stability as their south Asian counterparts (Modood et al., 1997).

Migrant settlers across all south Asian subgroups have been exposed to traditional English social and cultural conventions as Ballard (2002) argues that south Asians have acquired a high level of multi-cultural competence living in the UK. However, this does not necessarily mean they have abandoned their own cultural heritage. Many migrants are still attached to their places of origin, which influence their lives in other places (Ballard, 2002). In this context, many migrant south Asians can be described as belonging to the south Asian Diaspora.

2.1.8 South Asian Diaspora

The term 'Diaspora' is used to describe any population or group which have originated from a place other than that in which they currently reside and whose social and political networks cross international borders (Vertovec, 1999). The south Asian Diaspora describes people from south Asian countries who have belonging, displacement and connections to their homeland, and represents their overall experience of migration (Gupta et al., 2007). Nevertheless, south Asian migrants originate from various geographical locations and therefore do not share the same collective imagination (Singh, 2003). 'The Indian Diaspora' describes the collective imagining of India as a homeland, and the attachments Indian migrants hold to emotions, traditions and feelings associated with the motherland, and is thought to be made up of 17 million people (Singh, 2003). The term 'Indian Diaspora' is useful in how it specifically describes those from India who share a common imagination, as Singh (2003) explains, the Indian Diaspora lends itself to the idea that Indian migrants share common emotions and links to their homeland which can influence the way they live in new countries (Singh, 2003). However, India is a vast and

diverse country, home to a variety of regional castes, religions and languages. India is also home to different regional identities, including those who identify themselves as Goan, Tamil, Bengali or Punjabi. Therefore the 'Indian Diaspora' becomes a problematic term when attempting to describe a regionally diverse population. Thus 'Punjabi Diaspora' best describes the global movement of people who have ancestral roots in the Punjab (Tatla, 1999). It is important to clarify that references to the 'Punjabi Diaspora' in this thesis specifically refer to the population of first generation Indian Punjabis who migrated from the Punjab to the UK. Understanding Indian Punjabi migrants who live in the UK as part of the Punjab Diaspora identity brings their experiences and stories of migration to the foreground, Gupta et al. (2007) argue: "the narrativisation of diasporas thus highlight the diverse ways in which migrants themselves, the nations in which they have settled and the nations of origin represent Diaspora experiences" (Gupta et al., 2007:137).

The formation of the Punjabi Diaspora identity refers to both the individual identity and the collective group identity, as they are seen to be interrelated: "these two types of identity are distinct, it might be claimed that an individual develops a sense of identity through social practices and that practices are tied to the fact of identity" (Sahoo, 2006; 89). For example, Indian migrants manage their identity in host countries through language, dress and cuisine which are expressions of the Diasporic connection with the homeland (Sahoo, 2006). Nevertheless, the rise of globalisation and technological advances has altered first generation diasporic experiences, as communities become smaller due to transport and communication (Sahoo, 2006), which could be influencing how diverse Diaspora populations are engaged in complex relationships with their host and origin countries (Tambiah,

2000). For example, Singh (2003) argues that members of the modern migrant Diaspora are not engaged with India in the same way as their older generation counterparts. Due to the rise in globalisation and technological changes/cheap travel, migrants are becoming increasingly connected with India. Singh (2003) argues that these changes have altered how younger generations interact with the migrant Diaspora, as the homeland becomes more accessible.

These processes have important consequences for how second generation migrants experience their motherland, especially in relation to identity construction and negotiation of their hybrid identities (Hall, 1992; Bhachu, 1993; Brah, 1996). As a result, younger generations have complex linkages to their homeland and ancestral origins. For example, studies on south Asian adolescents in Britain have found that the younger generation are connected to the south Asian Diaspora, and are more aware of their ethnicity than their counterparts in India (Hutnik, 1991). In addition, it has been cited elsewhere that members of the second generation retain their heritage and choose to live in an ethnically mixed way (Modood et al., 1997; Robinson, 2005).

Exploring how the second generation connect with the Punjabi Diaspora could reveal decision-making processes behind health practices, as studies have shown that younger generation ethnic minorities are more likely to adhere to traditional health belief systems (Landrine and Klonoff 1994; Vohra and Broota, 1996; Furnham et al., 1999).

It is important to establish where exactly the Punjabi Diaspora originates from. The following provides a brief geographical overview of the Punjab state in India.

2.1.9 The Punjab

The historical geography of the Punjab has changed hugely over the course of modern history, between the Punjab of the Mughal times in the sixteenth century to the Punjab of the British period in the late nineteenth century. The following is a description of modern Indian Punjab which was created after the partition of India, which led to the division of the Punjab into West Punjab (Pakistani Punjab) and East Punjab (Indian Punjab) and the separation of Muslim and Hindu/Sikh populations (Singh, 2000). The Punjab is a state which borders Pakistan, located in north-western India. The name 'Punjab' has a literal meaning of 'five waters', which represents the land of five rivers in India. Provisional census data showed the population in Punjab to be over 27 million in 2011 (Census India, 2011).

The majority of the Punjabi population are Sikh, and is the largest religious community in the Punjab, with a population of over 14 million (Census India, 2001) (see Table 3):

Table 3. Census India 2001 (Population by religious communities)

State	Religious Communities	Persons	Males	Females
Punjab	All religious communities	24,358,99	12,985,045	11,373,954
	Hindu	8,997,942	4,874,765	4,123,177
	Muslim	382,045	213,023	169,022
	Christian	292,800	154,673	138,127
	Sikh	14,592,387	7,692,776	6,899,611
	Buddhist	41,487	22,171	19,316
	Jain	39,276	20,523	18,753
	Other	8,594	4,655	3,939

(Census India, 2001)

Sikhism originated in the Punjab, which is considered to be the homeland of the religion. The following section is a short description of the history of Sikhism and some common practices followed by Sikhs.

2.1.10 Sikhism

The word 'Sikh' comes from the Punjabi word 'sikhna', which means 'to learn'. A Sikh is someone who follows the teachings of Guru Nanak and his nine successors who lived in the Punjab during the late fifteenth century (Grewal, 1990; Cole and Sambhi 1997; Takhar, 2005). Guru Nanak established the Sikh religion, and his teachings were continued by nine other gurus after his death. The last guru, Guru Gobind Singh, declared no more Gurus to exist after him apart from the Guru Granth Sahib: the holy Sikh scripture. The Guru Granth Sahib encompasses all of the teachings from the gurus as well as other scholars at the time (Kalra et al., 2012), and is considered to be the heart of Sikhism as it influences Sikh living practices (Cole and Sambhi, 2005).

The philosophical foundations of Sikhism lie in the teachings of the ten gurus and are encompassed by the faith in 'waheguru', the belief in one formless god (ek onkar). God is perceived to be abstract and eternal, as the gurus rejected the creation of god into human form (Cole and Sambhi, 2005).

Guru Gobind Singh encompassed the Khalsa order (the pure ones) and the Sikh religious code, which observant Sikhs follow to demonstrate their dedication to the faith. Khalsa is the collective name given to describe all Sikhs who have been initiated into the religion by taking 'amrit', the holy water used in the baptism

ceremony 'amrit sanskar'. Baptised Sikhs are required to honour the Sikh code of conduct and adhere to the Five K's which require the follower to possess five items: Kes (uncut hair), Kanga, (comb), Kara (steel bracelet), Kirpan (sword), Kaccehra (undergarment). However, not all Sikhs are baptised and part of the Khalsa, as Sikhism is practised in a number of ways with various degrees of observations. For example, some followers may be uninitiated or cut their hair, but consider themselves to be Sikh.

Sikh festivals and celebrations include Vaisakhi (the Sikh new year/Birth of Khalsa) and Parkash Utsav Dasveh Patshah (celebration of the birth of Guru Gobind Singh). Sikh religious ceremonies include the Akhand-Path which is the uninterrupted reading of the Guru Granth Sahib, read to bless rites of passage such as birthdays. During these occasions, food and food preparation play an integral part in the worship practices, and often dictate what Sikhs should eat or drink on religious occasions (Kalra et al., 2012). The Gurdwara is the religious Sikh temple where members of the community congregate to carry out these customs and other ceremonies such as marriages, and is home to the Guru Granth Sahib.

2.1.11 Summary

Whilst it is known that T2D is becoming an epidemic in the UK, it is also affecting south Asians disproportionately. Evidence identifying the factors which attempt to explain why this is happening are unclear as current research still employs improper use of the term 'south Asian' to describe different populations. As a result, some groups are being neglected from the research focus. The differences and similarities

between south Asian subgroups will be explored later in the literature review which aims to further demonstrate the heterogeneity of the south Asian population.

In this research project, it is considered that the majority of the British Indian Punjabi community originate from the Indian Punjab, and are part of the Punjabi Diaspora. If we are to think of British migrant Punjabis in this way, then their connection with the homeland may have subsequent implications for the way they consider and manage their health.

The remainder of this chapter will discuss the concept of risk and the main approaches used to examine risk perception.

2.2 Part Two

2.2.1 Introduction

There are many different definitions of risk, with the majority of them centred on the probability of hazard and danger (Adams and Smith, 2001). One of the main foci in health risk research is risk from an epidemiological perspective. Epidemiological research evaluates the probability that certain events will occur in a given population, which is particularly important in accurately highlighting what risks exist, and who they are likely to affect. From this, there has been a growing interest in research which explores an individual's beliefs about the likelihood of risk occurring.

Risk perception is the term used to describe the attitudes and judgements individuals have about risk (Slovic, 1987). Lay risk perceptions are influenced by a number of factors including the severity and consequences of the risk occurring, as well as

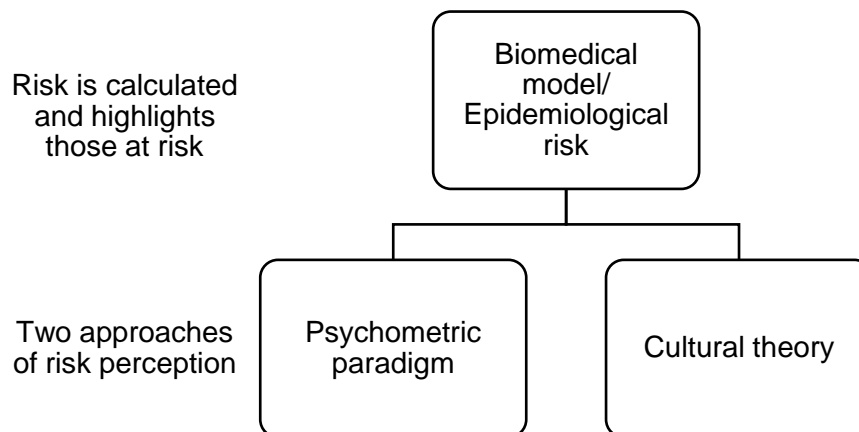
individual differences and personal belief systems (Walter and Britten, 2002). The physical consequences of risks such as death, injuries or harm are objective facts, yet how people assess and understand them are subjective and based on individual attitudes and beliefs. Therefore risk has different meanings to different people (Slovic, 2000).

Risk perception plays a significant part in the clinical care and self-management of south Asians with T2D. Self-management includes the modification of the 'big four' lifestyle risks which include smoking, alcohol consumption, physical activity levels and diet (Diabetes UK, 2009). Those who are identified as 'high risk' are encouraged by health-care professionals (HCPs) to monitor their behaviour, engage in self care, and manage their own risks (Kavanagh and Broom, 1998).

However, the successful self-management of T2D is dependent on how it is perceived as a risk to health, which can influence health behaviours. It is known that different south Asian groups hold varied belief systems which influence health behaviours (Greenhalgh et al., 1998; Rankin and Bhopal, 2001; Lawton et al., 2006). In addition, perceptions of risk about T2D are influenced by certain cultural beliefs such as fate, a concept which encompasses risk as something in the control of religion and/or a higher order. Exploring risk perceptions becomes important when attempting to uncover how different groups understand specific health risks related to T2D. This is particularly useful when attempting to design and tailor health-care services to the cultural needs of south Asians to further improve care.

The following describes two of the main approaches that examine risk perception: the psychometric paradigm and cultural theory. Figure 1 shows how the remainder of this chapter will explore risk and risk perception:

Figure 1. Discussion of risk and risk perception



2.2.2 The Biomedical model

Over the past two decades, health information has become more prominent in modern society. This has been demonstrated not only through the growing number of academic journals being published, but also with an increase in public engagement with health (Berry, 2004). Risk is a dominant feature within the field of health and health research, as ‘risk’ and ‘being at risk’ become increasingly used concepts within the medical context (Bennett et al., 2001).

The dominant model of medicine is biomedical, which was created for the study of disease (Blaxter, 2004). Based on molecular biology, it assumes disease to be “fully accounted for by the deviations from the norm of measurable biological variables” (Engel in Caplan et al., 2004:53). As a discipline, medicine has evolved over the

course of history to become a scientific practice, characterised by applied scientific methods to understand, treat and prevent disease and illness. Wade and Halligan (2004) summarise some of the key beliefs of the biomedical model (Figure 2):

Figure 2. Summary of biomedical model

- All illness and all symptoms and signs arise from an underlying abnormality within the body (usually in the functioning of structure of specific organs), referred to as a disease
- All diseases give rise to symptoms, and although other factors may influence the consequences of the disease, they are not related to its development or manifestations
- Health is the absence of disease
- Mental phenomena are separate from and unrelated to other disturbances of bodily function
- The patient is a passive recipient of treatment, although cooperation with treatment is expected

(Wade and Halligan, 2004: 1398)

In the biomedical model, health risks are measured and calculated through probability, and are treated as quantifiable facts which can be predicted and subject to control. As Lupton describes:

“risks, according to this model, are pre-existing in nature and in principle and are able to be identified through scientific measurement and calculation and controlled using this knowledge” (Lupton, 1999; 18).

Epidemiology is the study of the patterns of diseases that reveals how and why diseases occur in different populations (Rothman, 2012). In epidemiological terms, ‘risk’ is a type of measure of the number of new cases of a disease occurring within a specific time period (Broadbent, 2011). Epidemiology is a prominent feature of public health and informs evidence-based medicine through the identification of risk factors of disease.

Epidemiologists draw on a number of disciplines, such as biology, to define disease aetiology, and mathematical statistics and relative risk/risk ratios, which define the risk of the development of disease relative to exposure (Broadbent, 2011). Findings are based on study samples, chosen at random from target and study populations, which share a common characteristic such as disease prevalence.

There are three types of epidemiological studies: descriptive, analytical and experimental. Descriptive studies are mainly concerned with exploring the distribution of disease in a population, which can reveal risk factors for this group. Descriptive studies aim to identify changes in morbidity and/or mortality trends over time or compare prevalence of disease between different populations (Merrill, 2010).

Evidence has shown that lifestyle modifications and drug interventions can prevent diabetes (Knowler et al., 2002; Fowler et al., 2009). Therefore the importance of identifying at-risk populations early is crucial to implementing prevention strategies for those classified as high risk and reduce prevalence amongst the population.

Epidemiological studies of risk have made an important contribution to public health in identifying biomedical risk factors for disease and informing preventative medicine. Findings have contributed to medical knowledge about genetic and environmental risk factors for T2D, which have been identified as weight, waist circumference, age, physical activity levels and previous history of gestational diabetes or family history of T2D (NICE, 2011). Biomedical risks specific for south Asians have been identified as increased genetic predisposition to diabetes (Radha and Mohan, 2007), insulin resistance syndrome (Sharp et al., 1987) excess body fat and abdominal adiposity (Misra et al., 2004), and high plasma insulin levels (Mohan et al., 1986).

Within the field of chronic disease management, the diagnosis and management of conditions such as T2D are highly dependent on people's behaviours and belief systems (NICE, 2002). Especially since it is also known that there are differences in how the medical professional community and lay patients perceive and understand risk (Bickerstaff, 2004). By the identification of the 'at risk' population, health-care policies and decision makers are becoming increasingly aware of the need for interventions and increased care for those who need it the most.

Epidemiological studies and findings are only capable of looking at the incidence of disease in groups, and not the cause of disease. However, the biomedical and epidemiological approach do not aim to explore definitions of risk which lie outside of the medical field, such as the social aspect of illness. Therefore the biomedical approach to risk can be enhanced by the application of theoretical approaches which explore subjective risk perceptions.

2.2.3 Summary

Health risks are rational and calculated within epidemiological studies, which show which risks occur within different groups. The inquiry into how people think about risks are framed under two main approaches: the psychometric paradigm and cultural theory.

The psychometric paradigm derives from psychology, which addresses the cognitive processes in which risks are interpreted and represented. Whereas cultural theory explores risk from a sociological perspective, and contextualises risk within social and cultural contexts. These two approaches will be discussed next.

2.2.4 The Psychometric paradigm

The Psychometric paradigm aims to explain the factors which contribute to people's judgements about risk and identify the cognitive factors which influence responses to risk (Slovic, 1987; Heimer, 1988; Brown 1989). Developed by Fischhoff et al., (1978) and Slovic et al., (1986), the psychometric approach has been used to evaluate how lay people use different definitions of risk when understanding what risk means to them. Psychometric modelling of risk uses quantitative measures and analytical procedures to calculate risk perception and psychophysical scaling methods to produce representations of risk perceptions (Gardner and Gould, 1989). This approach is characterised by the assumption that human risk perception is multidimensional and is shaped by "scales that reflect characteristics of risks that are important in shaping human risk perception" (McDaniels et al., 1995; 576).

The primary aim of this approach is to identify the specific mental strategies which are used in making judgements about risk. From this perspective, respondents make quantitative judgements about current riskiness of hazards, which are then related to other properties which are summarised in Figure 3:

Figure 3. Risk properties

- The hazards status on characteristics that have been hypothesised to account for risk perceptions and attitudes
- The benefits each hazard provides to society
- The number of deaths caused by the hazard in an average year
- The number of deaths caused by the hazard in a disastrous year

(Slovic, 2000: 222)

Risk is also theorised from a cognitive approach, a theoretical framework which considers how risk perception is influenced by a number of psychological factors. Cognition models examine the predictors and precursors to health behaviours and risk behaviours and include the health belief model (HBM) (Rosenstock, 1966) and the protection motivation theory (PMT) (Rogers, 1975). Developed in the 1950s by the social psychologist Rosenstock (1966), the HBM aims to predict preventative health behaviours and risk perception. It has also been used to understand the behavioural response to treatment in chronically ill patients and the effectiveness of health education programmes. The model has been used to predict a wide range of health behaviours, and is based on the notion that an individual's belief of a risk, together with their belief of the effectiveness of a proposed action, will predict the likelihood of that risk. The PMT expands on the HBM to include additional factors such as response effectiveness and self-efficacy.

2.2.5 Limitations of the psychometric paradigm

It can be said that the psychometric approach to risk oversimplifies the causal relationship between risk beliefs and behavioural change. Psychometric approaches tend to view respondents as atomised individuals, and ignore the socio-demographic characteristics which may influence how people identify and understand risk (Bellaby, 1990; Cutter, 1993; Dickens 1992). For instance, the psychometric model does not fully explore the reasons why individuals differ in their perceptions of risk. In addition, the methods of scoring and quantitative analysis do not include opinions and meanings individuals might ascribe to risk judgements. In addition, the paradigm fails

to explore why individuals and groups might differ from each other in their risk perceptions.

Similarly to the psychometric approach, the HBM and PMT models focus on the individual, and exclude the role of social and economic factors on decision making. The models are also limited in that they presume that human behaviour is rational (Berry, 2004), and that there is a “linear relationship between knowledge of a risk, developing an attitude to that risk and adopting practices to prevent the risk from happening to the self” (Lupton, 1999:21).

The analysis of risk from a psychological lens is grounded in the theory that human behaviour is rational, and an individual is a rational actor who processes information in a value free context. Consequently, these approaches neglect the subjective meanings which are constructed in the social world which might influence decision making and judgements about risk (Rogers, 1997). The other dominant approach to risk perception that includes these factors is cultural theory, which will be explored next.

2.2.6 Cultural theory

The cultural theory of risk, or cultural theory, is a conceptual framework which seeks to explore empirical understandings of risk in society. Cultural theory considers risk as socially and culturally constructed (Douglas, 1986). Developed from a number of disciplines, including anthropology and sociology, cultural theory emphasises the role of social and cultural factors on the ways in which risks are constructed and

perceived in society to reveal the cultural contexts in which risks are interpreted and therefore exist “independently of the humans who assess and experiences them” (Bradbury, 1989; 389).

Cultural theory attempts to explain how and why people form judgements about danger and risks to show that judgements are influenced by social and cultural contexts. Cultural theory is interested in exploring the development of the cultural meaning of risk. From this perspective, the perceptions and views individuals have of the world are shaped by the social group they are a part of: “attitudes and judgements about risks are set in cultural relationships, namely the expectations and value systems of people belong to the distinctive groups” (Tansey and O’Riordan, 1999: 71). Cultural theory of risk explores the social structures within society which influence individual perceptions, and argues that “social responses to risk are determined by prototypes of cultural belief patterns” (Renn in Krimsky and Golding, 1992; 72).

Advocated by Mary Douglas (1966, 1978) and Douglas and Wildavsky (1982), the theory argues that risk perceptions are socially and culturally constructed phenomena (Douglas, 1978), and perceptions of risk are culturally conditioned ideas constructed through frameworks of understanding. The theory highlights the social processes which influence risk, and argues that perceptions of risk derive from individual experience. However, these experiences differ between different social groups. In this context, risk is not an objective entity, as each social group will define and perceive risk in a different way, therefore risk perceptions are based on an individual’s position in a cultural system (Douglas, 1986). Coming from a structural-functionalist perspective, Douglas argues that the reality of risk is predetermined by

our commitments towards different types of social solidarity. In addition, the social context of a person's life is seen to be governed by his or her beliefs. Therefore, individuals choose what to fear, and how much to fear (Douglas, 1986).

Individuals engage in selective attention to risk, which corresponds to cultural biases and social relations which are defined as "the number of distinctive patterns of interpersonal relationships: hierarchical, egalitarian, fatalistic or individualistic" (Wildavsky and Dake, 1990:43). In other words, an individual's perception of the world is based on and influenced by cultural biases which shape their view of society and nature. These world views and value systems influence risk perceptions, risk judgements, and preferences for risk management

The significance of cultural theory in the context of health-related risks is valuable in highlighting how different judgements about risk (expert or lay) are all influenced by the contexts in which they are made. This suggests that members of a common group might view reality in a particular way. Cultural theory emphasises that risk perception does not occur in a social vacuum. The implication suggests that exploration of risk perceptions cannot be fully done without consideration of the social and cultural contexts in which they are founded. This is particularly important when considering an alternative theory to risk perception which moves away from the individualistic approach, and provides a theory of risk which is widespread across groups and populations.

Nevertheless, cultural theory is problematic in explaining culture as culture has multiple meanings. Renn et al. (1992) highlight that this theory is lacking in that it distorts the definition of reality to fit in the predefined categories of cultural biases,

and reject the use of cultural theory on the basis that risk perception is far more complex than these categories suggest (Renn et al., 1992).

2.2.7 Summary

Life is not risk free, and people take risks in their lives. However, people vary in their risk taking. Within the perception of risk, some aspects can be objectively measured (psychometric measures), yet these methods alone are inadequate in explaining subjective perceptions of risk. Studies have shown that individuals evaluate risks not only on statistical data, but on other subjective factors (Adams and Smith, 2001). In addition, perceptions of risk are considered to be subconscious and subjective that do not follow any rational pattern (Calman, 1996).

The epistemological approach of any research about risk perception ultimately influences how it views and defines risk as a phenomenon. This thesis draws upon social constructionism to conceptualise lay perceptions of risk, which is discussed in Chapter Four.

The next chapter reviews some of the most relevant literature in this research study and includes an in-depth exploration of the differences that exist between south Asian subgroups' health beliefs and health practices related to T2D.

CHAPTER THREE: LITERATURE REVIEW

3.0 Introduction

The literature review undertaken for this study examines qualitative evidence on the health beliefs and health practices of south Asians¹ in the UK related to T2D. The objective of this review is to explore the social and cultural factors which influence health beliefs and health practices associated with T2D to reveal the heterogeneities which exist between different south Asian subgroups. Investigating what is already known about the health perceptions and behaviours of south Asians living in the UK has the potential to reveal the barriers and challenges this population face when attempting to conduct a healthy lifestyle. A synthesis of the literature will also help identify common themes across the population, and any unexplored areas needing further investigation.

As discussed in the previous chapter, south Asians living in the UK are at increased risk of T2D compared to the general population (NSF, 2001). Currently, the evidence on successful interventions developed for south Asians living in the UK is minimal (Bhopal, 2006), due to the fact that interventions are not culturally geared towards south Asians (Resnicow et al., 2000; Hawthorne et al., 2008). If intervention strategies are to be successful for south Asians, they need to be informed by their lifestyle, attitudes and beliefs. The health beliefs and health practices of south Asians are the focus of this literature review as they play an important role in their adherence to treatment and prevention strategies for T2D (Greenhalgh, 1997).

¹ Despite the problems associated with the use of the term 'south Asian' as previously addressed in chapter two, references will be made in this chapter to 'south Asians' as this is how they are currently described in the literature.

Medical sociology has experienced a shift in recent years in the way it is now focused on understanding lay health and illness experiences. This has been characterised by a move away from the outsider (professional) perspective, to the insider (patient) perspective, and a focus on lay subjective experiences in the context of everyday life to explore the micro and macro influences on health experiences (Bury, 1982; Williams, 1984; Lawton, 2003). This has included exploration into lay explanatory models, which reveal differences in individuals' perceptions of health and disease and how these might be influenced by cultural values, life experiences and beliefs about the epidemiology of a disease (Kleinman, 1980), as well as an individual's socio-cultural context and life experiences (Blaxter, 1983; Karasz, 2005).

Furthermore, evidence shows that personal models of illness can determine an individual's response to illness (Kleinman, 1980), which is particularly relevant to diabetes care when beliefs about diabetes can affect self-care, emotional well-being and medical outcomes (Skinner and Hampson, 2001). It has also been recognised that lay people and experts have different beliefs and attitudes about chronic disease management (McElroy and Jezewski, 2001). This can be partly explained by how patients and HCPs tend to focus on different aspects of illness, such as the social domain or the physiological problem (Cohen et al., 1994).

Knowing about lay health beliefs is particularly important in T2D care as it has been shown that if health education complies with people's lay epidemiology, it is more likely to be successful in facilitating behaviour change (Greenhalgh et al., 1998). Studies conducted on the south Asian population have shown their health beliefs to be different from those of European populations (Beishon and Nazroo, 1997; Anthony et al., 2012). For example, south Asians tend not to follow biomedical

models when explaining the cause of their diabetes, and are known to adhere to folk belief systems (Greenhalgh et al., 1998). The first part of this review will investigate studies exploring the health beliefs of south Asians in the UK, which predominately focus on perceptions of T2D causation.

Maintaining a healthy lifestyle is one of the recommendations for managing T2D which includes the management of modifiable risk factors including food and eating practices, physical activity, smoking and alcohol consumption (NICE, 2001).

However, culture has been identified as one of the biggest influences on health behaviour for south Asians (McAllister et al., 1992; Resnicow et al., 1999). Therefore, the second part of this review will examine the lifestyle practices of south Asians living in the UK to reveal the social and cultural factors that influence health behaviours and practices.

3.1 Search strategy

A search was conducted in the following electronic bibliographic databases:

Proquest, Swetswise and Science Direct which searched the following databases:

Applied Social Sciences Index and Abstracts (ASSIA), Sociological Abstracts, Social Science Citation and Web of Science. Articles for inclusion were papers exploring health beliefs and health practices of south Asians related to T2D based in the UK, and written in English.

A number of keywords were used as the terms 'south Asian', 'health beliefs' and 'health practices' have many synonyms, see Table 4.

Table 4. List of terms used in search strategy

Condition	Population	Health beliefs	Health practices
Type 2 Diabetes mellitus	South Asian	Perception of T2D	Food practices
Type 2 Diabetes	Asian	Health awareness	Food preparation
T2D	Indian	Health opinions	Diet
Diabetes	Pakistani	Health views	Eating habits
	Bangladeshi	Health attitudes	Exercise
	Sri Lankan	Health beliefs	Physical activity
	Punjabi	Causation/Causality beliefs	Alcohol consumption
	Gujarati	Religion	Drinking
	Kashmiri	Faith	Tobacco
	Sylheti	Sikhism	Smoking
	Sikhs	Hinduism	
	Hindus	Islam	
	Muslims	Buddhism	
	Buddhists		

The term ‘south Asian’ was defined as a population group with ancestral origins in India, Pakistan, Bangladesh and Sri Lanka. Therefore, the search included keywords which described people from those locations (Indian, Pakistani, Bangladeshi and Sri Lankan). It was important that the search reflected the heterogeneity of ‘south Asians’. Therefore, the search also included keywords which described sub-group populations such as; Punjabi, Gujarati, Kashmiri and Sylheti.

From this search, 862 articles were identified. This collection was then refined by the following parameters set for the selection of studies. Studies that reported qualitative findings about patterns of health beliefs and health practices related to T2D for south Asian ethnic groups were included. These qualitative papers were identified and selected through the review of paper titles and abstracts after the initial search had been conducted. The majority of studies that reported quantitative findings were excluded. However, a small selection of quantitative papers were included. These papers were included in the review as they provided statistical information about health practices, which contextualised the qualitative findings. The initial search revealed that Indian Punjabi men were under-represented. Therefore, the search was revisited and some papers outside of the UK were included if they discussed the health beliefs and/or health practices of Indian Punjabi men.

Eighty three papers were identified which specifically explored a variety of research questions related to health beliefs and health practices of south Asians and T2D. The common themes which emerged from the search have been organised into the following categories (see Table 5) and will be discussed in further detail next.

Table 5. Literature review themes

3.2.1 Health beliefs	3.2.2 Health practices
Perceptions of T2D	Food, diet and religion
Perceptions of causation and religion	Physical activity
	Tobacco smoking
	Alcohol consumption

3.2 Synthesis of the literature

3.2.1 Health beliefs

3.2.1.1 Perceptions of T2D

South Asians living in the UK tend to have little knowledge about T2D, and lack understanding of the relationship between lifestyle choices and T2D (Hawthorne, 1990; Simmons et al., 1991; Hawthorne and Tomlinson, 1997; Rankin and Bhopal, 2001).

Within the Bangladeshi community, the onset of T2D is attributed to a range of external influences including heredity and having family history which is a predictor due to its perceived 'inevitability' (Stone et al., 2005) and dietary factors such as the intake of sugar and a western diet (Kelleher and Islam, 1996; Rankin and Bhopal, 2001; Naeem, 2003; Meeto and Meeto, 2005). Onset of T2D is also associated with social isolation, as diabetics are labelled as 'out of control' in terms of their lifestyle choices (Grace et al., 2008). One study found that participant's awareness about risk factors increased due to family and friends' diagnosis, and the perceived

threat of T2D was enough to inspire preventative action in others (Grace et al., 2008).

However, not all south Asians draw upon the same factors when explaining T2D causation. Studies show that some Hindu Gujaratis have biomedical understanding of chronic disease, and recognise the importance of lifestyle modifications and are familiar with T2D through friends and family (Keval, 2009). Other evidence shows this group also recognise self-responsibility and psychological factors as contributing factors to health (Jobanputra and Furnham, 2005).

Whilst the evidence on Indian Punjabi men and their perceptions of T2D may be somewhat limited, some studies have shed light on how Punjabis as a group understand illness and disease. For example, they tend to ascribe to non-western models, and draw upon their own traditional health concepts in explaining illness and disease. Bhopal's (1986) discussion of the term 'bhye bhaddi' explores how Punjabis use this term as a health concept to describe disease caused by dietary imbalance. In Bhopal's study, Punjabis described the cause of 'bhye bhaddi' as the consumption of an imbalanced diet which was considered to be associated with ill health including excess saliva production (Bhopal, 1986). Similarly, Krause's (1989) investigation into the concept 'sinking heart' describes how Punjabis use this term to describe heart distress. Furthermore, 'sinking heart' describes physical pain in the chest associated with excessive heat, worry and social failure. Whilst Krause's study revealed the term to be a culturally bound explanation of physical symptoms, it also demonstrated how cultural ideas about the heart, the self and social/emotional problems are interconnected (Krause, 1989). These studies suggest that Punjabis subscribe to traditional interpretations of health problems. In addition, their understanding of

illness and disease are bound to cultural explanations which do not necessarily match traditional 'Western medicine' health concepts. Whilst these studies provide some insight into how Punjabis interpret health problems, overall, little is known about Indian Punjabi men's health beliefs about T2D and their health practices and how they differ from other south Asian subgroups.

For the majority of south Asians, religious belief is a major influence on health beliefs and perception of disease causation (Singh, 2000). The following addresses the literature on this area and explores the relationship between health beliefs and religion within the south Asian community.

3.2.1.2 Perceptions of causation and religion

For some south Asians, an individual's responsibility for their health is externally controlled and influenced by religion. Religion plays an influencing role in disease causation particularly amongst the Muslim population (Kelleher & Islam, 1996; Naeem, 2003, Meeto & Meeto, 2005; Stone et al., 2005).

Grace et al. (2008) compared the perspectives of T2D causation with south Asians and the white population and found the south Asians to be more likely to externalise the causes of their T2D. In addition, they were fatalistic about their condition, which seemed to originate from their religious beliefs (Grace et al., 2008). Fatalistic views are usually associated with south Asian religious beliefs, and some studies have found that some perceive ill health and T2D as a result of fate (Khan et al., 2008; Greenhalgh et al., 1998). Other examples include Naeem's (2003) investigation into the attitudes of Kashmiri men with T2D which revealed how their perceptions of

causation were externalised to higher powers of Allah/God. Similarly, Lawton et al.'s (2007) study among white and south Asian participants found that Pakistani respondents externalised disease causation and referred to the power of 'Allah's will'.

In Greenhalgh et al.'s (1998) study, the prevalence of religious fatalism in the community was considered to be common amongst older relatives rather than the participants themselves (Greenhalgh, 1998). Interestingly, even those who demonstrated awareness of their own role in maintaining their health spoke about religion and the role of God as being ultimately responsible for health (Greenhalgh, 1998).

The healing capabilities of religion have also been documented. In one study, Rozario (2009) investigated British Bangladeshis perception of healing and found that the responsibility for illness and cures was placed in the hands of Allah/God (Rozario, 2009). Spirituality was also drawn upon to distinguish between medical (daktari) and spiritual (jinn) illnesses (Rozario, 2009). In addition, Tirodkar et al.'s (2011) study of explanatory models of health and disease amongst south Asian immigrants found that Muslim respondents spoke more about the spiritual factors which influenced health decisions, and acknowledged the role of God in maintaining good health.

These studies demonstrate the influential role of religion for Muslim followers, where fatalistic views are reinforced by beliefs about health and illness which are predestined with Allah/God.

Studies have also explored the influence of other religions such as Hinduism on health beliefs. Hutchinson and Sharp (2008) have explored the role of karma as a

central religious concept for Hindu participants who described karma as affecting the length of life, illness and health. Whilst the relationship between karma and health was not fatalistic, it is influenced by environmental forces such as exercise, stress and diet (Hutchinson and Sharp, 2008). Hindus are also inclined to look to supernatural explanations of health and illness. Jobanputra et al.'s (2005) study on the health beliefs of British Hindu Gujaratis revealed both younger and older immigrants cited supernatural reasons for disease causation. Ill health was associated with karma and God, as well as the evil eye, and health advice was sourced from faith healers as opposed to health-care professionals (Jobanputra et al., 2005).

Despite the extensive evidence on the Muslim and Hindu population, not many studies have explored the influence of Sikhism on health beliefs within the Sikh community in the UK. In Canada, studies have explored the relationship between Sikhism and health which have found that Sikhs tend to refer to spiritualism as a way of life, and living a healthy lifestyle is seen to be synonymous with being a disciplined Sikh (Labun et al., 2007). This study also found that Sikhs became more spiritual during times of sickness, and called on God to intervene when medical interventions proved ineffective. In addition, participants also spoke about the correlation between health and maintaining a positive mentality, where body and mind were considered to be intertwined and affective of each other (Labun et al., 2007)

Bedi et al.'s (2008) study of older Canadian immigrant Sikh men's perspective of coronary heart disease risk found that Sikhism played an important role in how men understood heart disease as an illness. Oliffe et al.'s (2010) study examining the diet of Punjabi Sikh immigrant men in Canada also found that men's spiritual beliefs

influenced risky dietary practices. Men spoke about their life course as predetermined by kismet (destiny), which justified bad health choices for some Sikhs (Olliffe et al., 2010).

The following section will address the second part of this review, which is concerned with exploring the health practices of south Asians living in the UK.

3.2.2 Health practices

As previously mentioned, four modifiable health practices have been identified as playing a role in the development of T2D: dietary practices, physical activity, alcohol consumption and smoking. This part of the review will explore how these practices are carried out across the south Asian population to reveal the cultural differences which exist across the subgroups.

3.2.2.1 Food, diet and religion

Diet is one of the main factors in the rise in the prevalence of cardiovascular disease, T2D and obesity amongst south Asians living in western countries (Gillbert and Khokhar, 2008), with diet accounting for 30% of attributable risk of adult mortality in the UK (Wyke and Landman, 1997). Modifiable health risks related to food have been identified as high salt, sugar and fat intake. Studies have found that south Asians are at higher risk of consuming more of these foods as they tend to consume both traditional south Asian cuisines alongside western foods (Wyke and Landman, 1997; Chowdhury et al., 2000; Lawton et al., 2008; Vallianatos et al., 2008). Consequently, second and subsequent generation migrants are becoming increasingly at risk due to

their consumption of a high-fat diet through consumption of both traditional south Asian diet and western diet (McKeigue and Chaturvedi, 1996).

Evidence shows that the typical south Asian diet is high in fat, especially ghee which is used in traditional Indian cooking (Joshi et al., 2000). Studies show that south Asians living in Britain consume more energy, fat, meat and sugar than those living in their region of origin (Edwards et al., 2006; Patel et al., 2006). Joshi et al.'s (2000) study into fat intake amongst south Asians found that the average amount consumed was 37% which is higher than the recommended 30% allowance (Joshi et al., 2000). Food frequency data shows that south Asians, predominately Punjabi Muslims in Glasgow, eat more butter and meat and are more likely to drink full-fat cream and milk (Williams et al., 1994).

The consumption of traditional south Asian foods in the UK has been attributed to the shopping trends of British south Asians between 1947-75. During this time shopping hubs were created where south Asians could purchase culturally specific foods (Hamlett et al., 2008). As well as being used to purchase foods, the shopping hubs also had another function in that they became a place for social interaction, as shoppers from different ethnic communities were brought together (Hamlett et al., 2008).

Food is an important part of south Asian culture, and is considered to be integral to religious occasions and celebrations (Mennell et al., 1992; Counihan and Esterik, 1997). In addition, certain foodstuffs such as vegetables are being used for medicinal properties within the south Asian community to counteract T2D (Pieroni et al., 2007). However, the meaning of food and how it is consumed differs across the south Asian

subgroups. The following section will explore these differences to reveal how food is contextually situated in different cultural and religious norms.

South Asians perceive some aspects of the traditional south Asian diet as being 'risky' to health such as oil, fried foods and sugar (Lawton, 2008). Some foodstuffs are also considered to play a role in the causation of T2D. Greenhalgh et al. (1998) explored the perceptions of diabetes causation amongst British Bangladeshis who identified the excessive intake of sugar, and some features of the western diet, as playing an active role in the onset of T2D. The study focused on exploring underlying attitudes and belief systems which influence behaviour and diabetes management. Participants were recruited from three general practices in east London. Diabetes registers were accessed to identify diabetes patients who were approached to take part via letter. The study used a mix of qualitative methods to explore the subject's experience of diabetes including narrative interviews, semi-structured interviews and focus groups. The study revealed that foods were grouped together according to their perceived strength content and digestibility. Strong foods were seen to be those that have strength when consumed such as white sugar, lamb, beef, ghee, solid fat and spices. These foods were spoken about in relation to their capacity to provide strength and were often served to guests on celebratory events. Weak foods were seen as everyday foods, which included rice and cereals (Greenhalgh et al., 1998). However, there are limitations in this study, particularly within the sample. As participants were recruited from general practices, there was no inclusion of those who do not seek or receive Western medicine. Further work could be conducted to include these marginalised groups to explore their strategies for diabetes management. In addition, there was no exploration into generational differences as

the sample consisted of those from one generation. Further work could be done to examine any differences and/or similarities between these groups.

Other south Asian foods have also been recognised for their healing properties, such as bitter melon, which has the potential to reduce the symptoms of T2D (Grace et al., 2008). Sandhu et al. (2005) explored the use of complementary and alternative medicine in Sikh immigrant communities in London and found that 42 vegetables were recorded as being used in traditional Sikh medicine, such as onion, garlic, and cayenne pepper. Onion and garlic were reported as the popular vegetables that participants used for digestive problems such as indigestion, constipation and diarrhoea, and other illnesses such as colds and influenza, sore throat and chest infections (Sandhu et al., 2005).

Studies show that barriers to healthy practices do not necessarily derive from a lack of knowledge about T2D, but are determined by cultural structures which influence food and eating practices. For a lot of south Asians, food and eating practices are governed by social norms and values. In the social context, the consumption of lavish foods plays an important role in the offering and receiving which takes place within the context of 'gift giving'. Hospitality is fundamental to the consumption of south Asian food, and refraining from it carries social consequences such as alienation from a community. Bush et al. (1998) examined the ways in which food is prepared and served to meet the conventions of hospitality, and how obligatory patterns of food intake exist for south Asian and Italian women in Scotland. The study design consisted of interview schedules including both closed and open ended questions. The authors compared the food practices of Indian women, Italians and the general population in Scotland and found for Indian women, the traditional hospitality meal

played a significant role in the ways in which they prepare food for guests. The study found important differences in the ways in which Indian women created hospitality meals, which were seen to be a part of ordinary day-to-day life. Hospitality meals were elaborate and characterised by non-vegetarian food and fried foods such as pakoras and samosas (fried pastry snacks) (Bush et al., 1998). However, this study is limited in its explanation of why the south Asian women were more attached to traditional food and hospitality meals compared to the Italian group. In addition, the findings are not inclusive of south Asian men's perspectives and their influence on the creation of the hospitality meal. Further work could be done to reveal the underlying belief systems and attitudes which define these practices and behaviours for south Asian women and men.

Within the south Asian community, the perception of others is highly valued. Therefore certain foods are prepared in order to impress guests. This meant that for some, the acceptability surrounding 'healthy foods' such as plain food was reduced within the context of hospitality. Grace et al. (2008) found that certain foodstuffs such as plain lentils, rice and dhal was considered to be 'everyday food'. Special foods, such as fried snacks, were considered to be appropriate for guests as opposed to everyday food. The participants discussed the cultural implications of serving everyday food to guests, which was synonymous with inhospitable behaviour. The repercussions of serving everyday foods to others would also mean discrimination from others in the community (Grace et al., 2008).

Food also plays a role in the identity construction of the south Asian host. The serving of lavish foods to guests is acknowledged to be a display of the host's wealth and prosperity. Naeem's (2003) exploration of the experiences of diabetes control

amongst Kashmiri men in Leeds revealed how the consumption of fatty foods is directly associated with social success at informal social gatherings. The participants were identified through patient lists from a diabetes clinic over an eleven month period. Participants were then contacted via telephone and recruited via letter. The study design incorporated the use of interviews, using both structured and open ended questions. The study found that the consumption of fatty foods was considered to be a way of adhering to socio-cultural norms, where foods high in fat and sugar are prepared and served in excess to guests. It could be argued that these dietary patterns are linked to cultural norms and expectations of body image, where larger frames are associated with wealth and status (Naeem, 2003). However, as this study only included those who access health services it is limited in its representation of the wider Kashmiri male population. Further work could be done to include those who do not access health services to reveal any similarities or differences which exist between these groups in relation to their food intake and their adherence to cultural norms.

The preparation of tradition south Asian food remains a mostly gendered activity, which is seen to have originated from older models of socialisation where women carry out the majority of the cooking within the family (Nandy, 2004).

Few studies have explored the food and dietary practices of Indian Punjabis living in the UK. However, researchers in Canada have begun exploring the meanings of food among Punjabi families in Vancouver. Chapman et al. (2010) conducted a study examining the meaning of food, health and well-being embedded in the food practices of families of Punjabi heritage in Canada. Participants were recruited through key informants and snowball sampling. Semi-structured interviews took place

in the family home and included questions about family and individual eating patterns. The study found that food choices were influenced by external forces, such as family members, health concerns and work schedules. In addition, elders tend to be more reliant on traditional Indian food, whereas the younger generation have a preference for western foods. Participants also identified certain traditional foods as unhealthy, and recognised the importance of substituting for healthier options such as oil instead of butter (Chapman et al., 2010). One of the limitations of this study is that the sample included a disproportionate number of women. Therefore the findings may be more representative of the views of the women who took part in the study. However, other studies have explored the views of Punjabi men exclusively. In another Canadian study, Oliffe et al. (2010) explored the connections between masculinities and diet to examine how gendered ideals can inform and influence the practices of senior Punjabi Sikh Canadian immigrants. Participants were recruited from six community based Punjabi Sikh men's groups. Leaders of the groups were approached for access and researchers conducted fieldwork and participant observations. Six men from each group were recruited and participated in individual semi-structured interviews by a Punjabi speaking researcher. An ethnographic approach was used which included fieldwork, participant observation and individual semi-structured interviews. The study revealed how the men's consumption of traditional Indian food remained the same following migration. For the participants, traditional Indian foods were consumed as a source of production and fuel during their time as working farmers in the Punjab. During this time, food was a source of fuel which facilitated hard, laborious work. However, these dietary practices continued in Canada despite the absence of physical work and colder climates. In

addition, participants preferred traditional dishes and continued to consume them (Oliffe et al., 2010). However, the findings of this study may not reflect the dietary practices of all Punjabi Sikh Canadians as the majority of the participants were senior and retired. Further work in this area could be conducted to explore the effects of work on diet and dietary practices for this population.

Food also plays an integral role in Sikh faith. Labun and Emblen (2007) explored the relationship between health and illness amongst Sikh immigrants in Canada and found that faith influences food choices and diet. Sikhism advocates vegetarianism, which is directly assimilated with being compliant with Sikh faith. In addition, connecting spirituality with Sikhism was described as being attainable through the consumption of good, plain and simple foods. Food is also a part of a cycle process that fortifies the heart, an integral organ that influences actions and decision making (Labun and Emblen, 2007).

Religion also influences the food practices of other groups. Ramadan is a religious ritual for many adult Muslims who fast between dawn and sunset during the holy month (Chowdhury et al., 2003; Akbhani et al., 2005). The sharing of traditional foods is a common cultural practice within the Hindu community, especially during times of celebration such as Diwali (new year's day), Navrati (death of the demon Ravana) and Holi (festival of colours) (Patel et al., 2001).

The studies presented here reveal the influence of cultural and social norms on the food and eating practices of south Asians. The value placed on social expectations and hospitality appear to have detrimental effects on the evaluated health risk of this group. This literature can serve to remind HCPs that south Asian food and eating

practices are governed by social norms, which make the modification of eating practices particularly challenging: 'when meals are closely governed by traditional symbolism, the room for change as a result of health or other new considerations is reduced' (Bush et al., 1998: 376).

The literature exploring the food and eating practices of the Indian Punjabi community in the UK is somewhat limited. Studies conducted abroad show that the Indian Punjabi diet is typically high in fat, and the preparation of food is a gendered activity. Despite this, there is a lack of focus on food preparation practices and how food is consumed within the context of everyday life. Whereas Canadian studies have demonstrated the tentative links between food sustenance, masculinity and Sikhism, more needs to be done to understand Indian Punjabi dietary practices and the implications they pose for T2D management in the UK. The next section will review the literature on physical activity.

3.2.2.2 Physical activity

The health benefits of physical activity have been heavily documented in the literature, which shows that regular activity can reduce the risk of developing chronic diseases such as T2D (Manson et al., 1991). Current physical activity guidelines, recommended by the UK Chief Medical Officers state that adults should complete 150 minutes of moderate intensity physical activity a week (DOH, 2011). Exercise has also been proven to reduce HbA1c levels (Boule et al., 2001).

Despite this, south Asians represent one of the groups with the lowest levels of physical activity compared to the general population (HSE, 2004), and are less likely

to exercise than the general population (Williams et al., 1994; Fischbacher et al., 2004; Williams, 2010). Results from the HSE (2004) found that only 11% of Bangladeshi and 14% of Pakistani women did the recommended amounts of physical activity (HSE, 2004). The highest prevalence of low activity levels were observed amongst Bangladeshi and Pakistani men (both 51%) and Bangladeshi (68%) and Pakistani (52%) women (HSE, 2004).

The role of physical activity in the prevention of T2D is widely acknowledged, however evidence shows that the participation of south Asians in exercise and physical activity remains low (Lawton et al., 2006). Doing exercise or taking part in physical activity for health purposes or enjoyment is not commonplace for many south Asians.

South Asians appear to have a lack of motivation for exercise, and place importance on the adherence to social norms such as socialising with others and maintaining modesty (Grace et al., 2008). External barriers also reduced the likelihood of exercise for some, such as bad weather, which meant a preference for staying indoors (Lawton et al., 2006).

The literature reports that south Asians face a number of challenges with behaviour change and physical activity due to cultural and religious barriers. Horne and Tierney (2012) synthesised the views and experiences of south Asians in relation to exercise and physical activity and found disempowering concepts influenced physical activity in relation to communication, relationships, beliefs and environment. Lack of information, support or overprotective family or group norms hindered how south Asians participated in physical activity (Horne and Tierney, 2012).

South Asian women also face barriers to physical activity. Khanam and Costarelli's (2008) study into the attitudes and beliefs of overweight and obese Bangladeshi women on health and exercise found that they faced external barriers which they had little control over. Participants were recruited from a local sports centre and a local mosque. All of the participants were overweight or obese and had been referred to the gym by their GP. An interview-guided questionnaire was used which included questions about health awareness and attitudes towards exercise. The study found that the women would not join the gym voluntarily if it had not been recommended by their GP. Also, the women did not perceive themselves to be overweight. In addition, the study also showed that cultural restrictions imposed on a number of activities, such as walking fast outdoors (Khanam and Costarelli, 2008). Further work could be conducted to explore the extent to which these cultural restrictions impact on other health related behaviours such as diet and food preparation.

For some south Asian women, the concept of exercise is perceived to be a selfish activity, which takes time away from them completing family orientated tasks and duties (Sriskantharajah and Kai, 2006; Ludwig et al., 2011). Other restrictions placed on south Asian women include not being able to leave the home (which was considered to be the traditional social norm for married women), fear and shame in being in a public space, perceived threat of harm, modesty, language and lack of appropriate facilities (Lawton et al., 2006; Sriskantharajah and Kai, 2006).

Not much is known about the physical activity of Indian Punjabi men in the UK, or their attitudes towards physical activity and how they understand physical activity in relation to health and illness. Oliffe et al. (2009) explored some of these issues amongst Sikh men in Canada; men spoke about their perceptions of ageing,

musculoskeletal impairment, and the cold weather climate, which were cited as the main barriers to physical activity. Perceived ideals of masculinity inform men's physical activity levels. Interestingly, the social benefits of physical activities such as walking were described as a way of connecting with others in the community.

South Asians, and in particular Muslim women, appear to face a number of complex structural and cultural barriers when taking part in physical activity. The findings of the literature suggest that gender separated activities would be culturally appropriate for south Asian women in particular. There is a need for similar studies to be replicated in the UK which focus on the structural and cultural barriers the British Indian Punjabi community face to physical activity. The following examines the literature on the smoking practices of south Asians in the UK.

3.2.2.3 Tobacco smoking

Smoking greatly increases the risk of cardiovascular disease and microvascular disease in people with T2D (Diabetes UK, 2012). Studies show that people with T2D who smoke tend to come from disadvantaged socio-economic backgrounds (Gulliford et al., 2003). Within the south Asian community, smoking is not restricted to tobacco use but also includes other substances such as handmade bidi and chewed tobacco paan (Croucher et al., 2007).

The prevalence of smoking varies greatly among ethnic groups, who generally smoke less than the general population. Nevertheless there are significant differences between ethnic groups. Milward et al., (2012) analysed combined data from the HSE's (2006, 2007, 2008) to show that amongst men, black Caribbean

(37%) and Bangladeshis (36%) have the highest smoking rates, followed by Chinese (31%). Indian (15%) and other black men (12%) had the lowest smoking rates (Milward et al., 2012). Other studies report similar findings, with smoking rates significantly higher amongst Bangladeshis compared to other south Asian groups (Silman et al., 1985; McKeigue et al., 1988). Croucher et al.'s (2007) study into concurrent tobacco use amongst Bangladeshi men in the UK confirmed high tobacco use, with 68% of the men using different tobacco types daily.

Studies investigating smoking behaviours primarily focus on the male Muslim population, who appear to be the most prolific smokers in the south Asian community. This could be due to the fact that smoking is a gendered activity and begins at a young age for some Bangladeshis (Markham et al., 2001; Bush et al., 2003). Denscombe and Drucquer (2000) conducted a survey study of alcohol and tobacco consumption amongst 15- and 16-year-old south Asians in the East Midlands and found that levels of tobacco consumption increased over a seven-year period. There were also differing levels of smoking patterns between groups, with little differences of smoking between Hindu and Sikh males; nevertheless there had been an increase in smoking amongst Muslim males (Denscombe and Drucquer, 2000).

For some Muslims, smoking is influenced by a number of factors related to religion, gender, age and tradition (Bush et al., 2003). This group also face a number of external barriers when attempting to quit. White et al. (2006) explored the attitudes to quitting smoking and experience of smoking cessation amongst Bangladeshi and Pakistani ethnic minority groups. Participants were selected by a community participatory research approach in which members of the Bangladeshi and Pakistani

communities in Newcastle contributed to the study development, implementation and analysis. The study found that found barriers were associated with social pressure from other smokers and experiencing stressful events which prompted smoking. Older participants admitted to never attempting to quit, and rationalised reasons for their smoking as being due to socialising with others. Whilst reasons for wanting to quit related to health risks, witnessing smoking-related illness in others motivated some to quit. Formal and informal methods were also called upon in an effort to quit which included willpower and formal interventions. This study found that the motivation to quit was high due to financial reasons, pressure from family and friends and religious reasons (White et al., 2006). This study is limited because its findings may not be generalisable to other ethnic minority groups. Therefore, further work could be conducted exploring experiences of smoking cessation within other groups.

Smoking is less socially acceptable within the British Indian community, making it less of a risk factor for this group (Williams et al., 1994; Anthony et al., 2011).

These studies show that some south Asians are more prone to smoke than others. However, the reasons why they are more likely to smoke compared to other groups are not fully explored. Evidence shows that whilst smoking appears to be more of a risk factor for Muslim males, other groups face other risk factors associated with alcohol consumption (Vora et al., 2000), which will be explored next.

3.2.2.4 Alcohol consumption

Similarly to tobacco use, alcohol consumption and alcohol related health problems appear to be lower in ethnic minority communities compared to the general white population (Balarajan and Yuen, 1986; Cochrane and Howell, 1995; Nazroo, 1997).

Despite this, drinking patterns amongst the south Asian subgroups is varied.

Bangladeshi and Pakistani groups tend to report low levels of alcohol consumption, (McKeigue et al., 1988; Purser et al., 2001; Heim et al., 2004), due to religious beliefs associated with Islam (Williams et al., 1994). However, evidence shows that Punjabi Sikh men are at higher risk of alcohol abuse than any other south Asian group (Cochrane and Bal, 1990; Ahuja et al., 2003; Morjaria-Keval, 2006; Singh et al., 2006), with heavy spirit drinking common amongst Sikh men (McKeigue and Karmi, 1993).

Studies conducted on the alcohol consumption of Indian immigrant men report higher rates of alcohol-related disorders (Sandhu and Malik, 2001). A recent literature review of drinking patterns and alcohol service provision for different ethnic groups in the UK found that Sikh men represent the group with the highest consumption as well as over-representation for liver cirrhosis (Baylet and Hurcombe, 2010).

Alcohol consumption and alcohol-related health problems appear to be rife amongst the Indian male population. The function and purpose of alcohol for Indian men appears to be multifaceted in different contexts. During the period immediately after migration, alcohol was used by Indian men who experienced stress and depression as a coping mechanism. In addition, alcohol facilitated socialisation and male bonding with others (Cochrane and Bal, 1990; Bedi et al., 2008). Alcohol was also perceived to be a fortifying drink which aided physical work (Cochrane and Bal, 1990).

Indian Punjabi men's problematic relationship with alcohol is considered to have begun before migration (Sandhu, 2009). Sandhu (2009) explored the socio-cultural context of alcohol consumption and its role in identity construction, especially in

relation to status, land ownership and masculinity. Sandhu argues that the cultural messages surrounding alcohol which relate to status are a common feature of typical 'Punjabi masculine bravado' which is endorsed through drinking as a way of displaying masculinity. Sandhu's (2009) exploration of Sikh attitudes to alcohol use takes into account the dichotomy that exists between Sikh values and Punjabi cultural attitudes towards alcohol use. For example, in the Punjab, alcohol is a status symbol amongst landowners and the upper classes, and plays a significant role in social lifestyles (Sandhu, 2009). Sandhu explains how alcohol has been the cause of problems in the Punjab since the early 1900s, and continues to be a social problem today. Part of the explanation is associated with cultural masculine ideas, which dictate how Punjabi men are expected carry out their masculine identity. Those who comply with this cultural ideal of masculinity are often labelled as 'sher Punjabi' (Punjabi lion), which is a colloquial term to describe a strong Punjabi man. In addition, alcohol is commonly referenced in Punjabi folk songs, Bhangra music and Bollywood films, which promote the pro-attitude to alcohol consumption within Punjabi male culture (Nagra, 2011).

Sandhu (2009) shares his concerns about the Punjabi migrant community in the UK, and how similar trends are being replicated within the Punjabi Diaspora across a number of developed countries, such as the USA, Canada and the UK (Sandhu, 2009). Sandhu argues that the migratory move and subsequent implications have contributed to this group's excessive consumption of alcohol. Sandhu also highlights that their migration was not only one of location, but also a move from a collective-traditional society, to an individualistic-modern society. This is considered to have

contributed to the breakdown of traditional collectivist Punjabi values, which have been replaced with anonymity and egalitarianism in the UK (Sandhu, 2009).

In addition, the drinking habits of second-generation Indian Punjabi migrants seem to be replicating the behaviours of their elders. Heim et al.'s (2004) study into the alcohol consumption of young adults aged 16-25 found that Indians self-reported the highest levels of drinking. Similarly, Orford et al.'s (2004) study into the drinking habits of second-generation black and Asians reported black men and women and Sikh men to be the highest reporters of drinking. Reasons cited for drinking were associated with the benefits of drinking, which increased self-confidence and relaxation. High abstinence was reported from Hindu, Pakistani and Bengali men and women, and Sikh women. Similarly to their adult counterparts, young adults from Muslim backgrounds are less likely to consume alcohol compared to other south Asian groups (Denscombe, and Drucquer, 2000).

Whilst Muslim groups tend to abstain due to religious observances, the same does not seem to apply for Sikh men. This suggests that Indian Punjabi Sikh men identify with their cultural heritage, rather than their religious (Sikh) identity. Sandhu's (2009) discussion of the links between Sikhism and alcohol serve as an important reminder of the difference between the 'Sikh world' and the 'Punjabi world'. Sandhu argues that if we are to consider the Sikh world in a clinical setting, then it is not enough to assume that a Sikh (Kaur or Singh) is a follower of Sikhism per se. Sandhu argues that more often than not, Sikh patients tend to identify with their Punjabi culture, and view Sikhism as part of their heritage (Nayar, 2004).

The continued excessive use of alcohol is considered a problem for the diasporan Punjabi community who live in western countries where they have continued to show higher levels of consumption in comparison to other south Asians. Explanations put by Sandhu relate to the Punjabi agricultural background, which has seen alcohol used for medicinal and social purposes. In addition to this, the role alcohol plays in masculine identity construction is deeply embedded within Punjabi culture and rhetoric.

Despite this, there is insufficient evidence about the effectiveness of alcohol prevention programmes for members of the south Asian community. Johnson et al's. (2006) exploration into alcohol education and service provision for south Asian and African Caribbean communities found that more primary research is needed, especially a focus on interventions to reduce alcohol misuse and subsequent research to evaluate their effectiveness (Johnson et al, 2006). In addition, further work could be conducted to illuminate the key factors which play a role in sobriety for south Asian men. For example, Morjaria (2002) explored the spiritual aspect of recovery for south Asian men with alcohol problems and found that they underwent a re-affirmation of existing beliefs which played a key role in their recovery (Morjaria, 2002).

The differences in alcohol consumption between south Asian groups suggests there need to be distinct approaches which target at-risk populations in relation to service provisions and interventions. Rao (2006) highlights that alcohol misuse cannot be addressed by a broad population approach without culturally appropriate services to meet the needs of minority ethnic groups, which cannot be done without knowledge about specific populations, which at the moment remains relatively unknown.

The literature presented in this chapter highlights the need for a focus on British Sikh/Indian Punjabi men and their health practices related to alcohol. There is currently a lack of studies which explore the reasoning behind alcohol use amongst Sikh men living in the UK.

3.2.3 Conclusion

The exploration of the key texts in the literature prompts the discussion of a number of key points.

Firstly, the evidence reveals the commonalities which exist across the south Asian population in regards to their health beliefs and health practices related to T2D. In terms of their knowledge about T2D, this group have significant knowledge gaps, and lack understanding about the relationship between modifiable risks and chronic disease. This is largely due to the fact that south Asians are more likely to adhere to lay explanatory models of health when attributing causation. As well as this, south Asians consume a traditional diet which is characterised by the use of popular ingredients including fat, ghee and sugar.

The most important finding from the review is that south Asians' health beliefs and practices are heavily influenced by cultural norms and socio-cultural values. From religion to cultural appropriateness, these concepts are deeply embedded in everyday life experiences and consequently govern how some south Asians understand health and engage in health practices.

It is important to establish that whilst cultural and social factors play a major role in the health outcomes of south Asians, they are not uniform across the population. The evidence from the literature shows that some cultural constructs are of more prominence amongst some south Asian subgroups than others. For example, religion and fatalism are widely drawn upon in lay explanatory models of causation of T2D amongst Bangladeshis and Pakistanis. However, religion seems to be less of a factor for other religious groups. In addition, different south Asian groups face different barriers to health behaviours. Whilst physical activity remains low amongst all south Asians, Bangladeshi women face a number of cultural barriers which restrict their uptake of exercise. These barriers appear to be bound to Bangladeshi cultural expectations surrounding modesty and cultural appropriateness, which are highly valued within this subgroup. Whereas Indian Punjabi men living in Canada face structural barriers to exercise relating to the environment, weather and climate. Similarly, excessive alcohol consumption is reported less amongst the Pakistani and Bangladeshi community as alcohol is forbidden within their religious principles, however it is a major risk factor for Indian men.

The literature featured in this review, and in the wider context does not clearly establish these heterogeneities that exist between south Asian subgroups. This is largely due to the usage of the umbrella term 'south Asian', which groups together a widely diverse population. The dangers associated with this include the implication that the same social and cultural factors apply to all south Asians neatly and influence them in the same way. This problem can be addressed by limiting the use of the term 'south Asian' in the literature, and to instead describe them by their subgroup identity to reveal the subtle differences which occur between groups. In

addition, the description of south Asians should also be inclusive of those from different migratory trajectories. For example, 'twice migrants' refers to the migrated community of east African Sikhs in the UK, who are different from other south Asians in terms of their socio-cultural experiences and socio-economic backgrounds (Bhachu, 1990).

The homogenisation of south Asians also has implications for the design of interventions aimed at this group. Whilst culturally specific self-management education has been developed for south Asian communities in the UK (Davies et al, 2008), the approach is limited in how it has been designed for the whole south Asian community. Whilst programmes may be tailored towards specific cultural needs, randomised control trial evidence has shown that enhanced care for south Asians with T2D does not improve glycaemic control (O'Hare et al, 2004). The literature demonstrates that south Asians may not be suited to current models of behaviour change based on individual responsibility and self-efficacy, therefore intervention strategies should be designed to meet the specific needs of individual south Asian subgroups. For example, educating Bangladeshis and Pakistanis about the health risks associated with alcohol consumption would be superfluous.

This review also highlights the absence of Indian Punjabi men, which can be constituted as a significant gap in the literature. A few studies have identified common lifestyle practices of Indian Punjabi men, such as their increased consumption of alcohol compared to other south Asian men. However, not much has been done to explore the reasons behind this trend.

With the prevalence of T2D expected to rise amongst south Asians, there is a need for the literature to clearly distinguish the health beliefs and health practices which influence T2D risk for different south Asian subgroups.

The next chapter describes the methodology and methods selected for this research.

CHAPTER FOUR: METHODOLOGY AND METHODS

4.0 Introduction

This chapter begins with a discussion of the ontological and epistemological frameworks and how they influenced the research paradigm. The second part of this chapter addresses issues related to methods, including the narrative inquiry approach adopted, sampling process, data collection and analysis.

4.1 Developing the methodology

4.1.1 Ontology and human nature

The justification of any methods employed within the social sciences is based on assumptions regarding ontology and human nature. Ontology is the philosophical study of the nature of reality, forms and conceptions of realities, and more specifically, how realities are composed of multiple constructions which are socially based by individuals and groups who form them (Kienzle, 1970). Ontology describes two main perceptions of reality and how individuals determine realities either through their experience of it (subjectivism) or as it exists independently from them (objectivism) (Morgan and Smircich, 1980).

This research takes the ontological stance that individuals experience realities subjectively, which reinforces the notion that individuals can only understand and know reality which is accessible through their own experiences and interpretations. Questions about how those realities can come to be known and definitions of

knowledge are explored by epistemology. Epistemological assumptions explore the nature of knowledge, question our ideas about knowledge and the best way of inquiring into this knowledge (Denzin and Lincoln, 2003).

As previously mentioned, this research derives from the subjectivist approach, which is characterised by the ontological assumption that reality is a product of social construction (Morgan and Smircich, 1980). This ontological assumption of reality lends itself to explain how human beings create their own realities:

“Human beings create their realities in the most fundamental ways, in an attempt to make their world intelligible to themselves and to others. They are not simply actors interpreting their situations in meaningful ways, for there are no situations other than those which individuals bring into being through their own creative activity” (Morgan and Smircich, 1980:494)

The subjectivist approach advocates that reality is constructed through the individual. Therefore, the epistemological approach must be suited towards understanding human behaviour, the individual's relationship with the world and how meaning is constructed. Therefore, social constructionism is the most appropriate epistemological framework for this research study as it is primarily focused on exploring the social structures which influence human experience.

The following section explores the origins of social constructionism, and the application of it in this study as the main epistemological framework to investigate how individuals create meanings, perceptions and understandings about health and T2D.

4.1.2 Epistemological framework; Social constructionism

The ontological stance of this study influences the epistemological framework, which dictates that knowledge and how we know about knowledge can be found and located within the individual and their experiences of their life world. One approach to uncovering this knowledge is social constructionism, which advocates that language and other cultural signs are significant as the means by which individuals construct reality (Berger and Luckmann, 1966). Therefore a social phenomenon, such as culture, is the product of and is sustained by human practices. In addition, social constructionism aims to highlight the ways in which individuals come to explain and describe their experiences of the social world in which they exist (Gergen and Gergen, 2003).

Social constructionism advocates that human beings are active agents rather than submissive organisms, and human life is considered to be a product of a multitude of processes which are carried out in the context of cultural purposes beliefs and stories (Berger and Luckmann, 1966). Central to social constructionism is the view that reality is constructed by numerous world views by individuals as they interact. These interactions produce multiple realities which form institutions in society such as religion, philosophy and culture (Berger and Luckmann, 1966).

Applied to this study, the social constructionist framework aims to reveal how individual life experiences have become situated within a specific cultural context. The emphasis of the participant's individual life experience is central to this study as a means to understand how knowledge and realities of health beliefs have been created. Investigating the life experience is a means of accessing the ways in which

individuals create understandings of their world to reveal the social constructions influencing health beliefs and perceptions.

The following section begins with an examination of the underlying principles of social constructionism, phenomenology, and includes the rationale for the use of social constructionism and narrative inquiry approach in this study.

4.1.3 Schutz and the Phenomenological Sociology of Everyday Life

The philosophical roots of social constructionism are considered to be the phenomenological work of Alfred Schutz (1962, 1964, 1966). The founder of phenomenological sociology, Schutz's work, inspired by Weber's interpretive sociology (1922), called for the examination of everyday life and a sociological theory to explore this phenomenon.

Schutz's examination of social phenomena is primarily concerned with the structures of the life world to account for the ways in which meanings are constructed through intersubjectivity (Schutz, 1964). According to Schutz, the social world and its meaning are created and constituted by individuals in society (Schutz, 1964).

Therefore in order for an understanding of the social world to be achieved, there is a need to examine the social individuals for whom it exists.

Schutz rejects positivistic and reductionist theories which reduce human action to observable behaviour, but emphasises the need for theory to understand the phenomena concerned with the individual in society such as consciousness and motives to reveal how they influence social action. Schutz argues that the analytical

gaze of sociology should be on the individual as well as larger sociological structures such as classes, gender or sex.

In addition, knowledge production has three components: structural socialisation, genetic socialisation and social distribution (Schutz, 1964). Structural socialisation refers to the ways in which the knowledge that individuals possess is the same as the knowledge others have. In addition, knowledge is socially distributed in the ways in which knowledge is differentiated between individuals as some have more knowledge than others. Schutz maintains that the social distribution of knowledge is not explored in detail and that the field of the sociology of knowledge should be primarily concerned with the life world and how it is experienced by individuals (Schutz, 1964).

The following section examines the work of Berger and Luckmann in *The Social Construction of Reality* (1966), which draws upon the phenomenological work of Schutz to emphasise the experience of the individual self, the self in relation to others and how meaning is constituted in society.

4.1.4 Berger and Luckmann and the Social Construction of reality

Berger and Luckmann (1966) adopt an anti-realist approach to analyse the phenomena of social life. The authors state that in order to know what is real about the world, the sociology of knowledge must explore the empirical variety of knowledge that exists within society and the processes involved when any specific knowledge becomes a reality (Berger and Luckmann, 1966: 15). From an epistemological perspective, social constructionism is primarily concerned with

exploring individuals in society and how social interactions come to be perceived as objective reality. Berger and Luckmann reject the claim that social reality can be seen as an objective entity: “social order exists only as a product of human activity” (Berger and Luckmann 1966; 70).

From this perspective, individual knowledge is not an objective perception of reality but is constructed between individuals as versions of reality arise between individuals (Berger and Luckmann, 1966). Individuals in society are seen to create and sustain phenomena via social practices through externalisation, objectification and internalisation. Externalisation refers to the ways in which individuals come to act on their world to create social practices (Berger and Luckmann, 1966). These social practices then become objectified as possessing objective fact which is perceived as truth. As social practices are social constructions, internalisation occurs as individuals are born into a world where such social practices are already in existence. Therefore social practices become internalised as part of an individual’s consciousness and their understanding of the world (Berger and Luckmann, 1966).

Applied to this research study, this perspective can be used to understand how people’s beliefs and understandings about health (social phenomenon) are the product of social constructions. In addition, this approach can reveal how subjective meanings about health come to be internalised as objective fact within cultural and social contexts as; “all ways of understanding are historically and culturally relative” (Burr, 1995; 4).

Therefore the ways in which health perceptions of T2D are defined by the historical and cultural contexts that surround the participant, in turn influences their

perceptions. Therefore, culture knowledge and meaning become of primary importance for analysis if there is to be an interpretive investigation into perceptions of health.

Berger and Luckmann also emphasise that whilst the world is socially constructed by individuals, at the same time it is experienced as an objective fixed entity (Berger and Luckmann, 1966). The perspective also explores how the social construction of reality occurs through everyday life, language and knowledge.

Everyday life is described by Berger and Luckmann as a reality which is interpreted subjectively by the individual: “everyday life presents itself as a reality interpreted by men and subjectively meaningful for them as a coherent world” (Berger and Luckmann, 1966: 33). The everyday life is a world that the individual shares with others. Despite the fact that worlds are experienced differently, there is an awareness of “the common sense about reality and the shared meanings in the world between others and the individual” (Berger and Luckmann, 1966: 37). This process is described as ‘taken for granted’ by members of society: “the world of everyday life is not only taken for granted as reality by the ordinary members of society in the subjectively meaningful conduct of their lives. It is a world that originates in their thoughts and actions” (Berger and Luckmann, 1966: 33).

Social interaction is an integral part of everyday life, with language being an important sign in society (Berger and Luckmann, 1966). From this perspective, language possesses the quality of objectivity whilst also having the capacity to act upon the individual (Berger and Luckmann, 1966; 53). It is expansive in nature and allows for the individual to objectively re-tell life experiences to others. It is in this way

that language can connect to individuals. In addition, language is utilised by individuals to socially construct their reality through the shared meanings communicated through language. This gives way to the notion that individual beliefs about the world are social constructions.

Nevertheless, social constructions are governed by normative rules as they are situated by historical and cultural contexts as language is constantly changing throughout the course of time (Burr, 1995). Therefore, language contributes to the social construction of reality as it pre-dates the existence of the individual (Burr, 1995). Here, language is seen to be a fundamental social phenomenon which occurs in interaction and consequently shapes thoughts and perceptions. Therefore language is used as a system which individuals call upon to reproduce their experiences to give meaning to their lives.

Berger and Luckmann (1966) state that all knowledge, including 'taken for granted' knowledge, originates and is maintained by social interactions. They state that knowledge is not exclusively natural as it is bound to historical and cultural contexts (Berger and Luckmann, 1966). Here, knowledge is created and sustained through interactions in society. From this perspective, knowledge and interpretations about the world are socially constructed. Berger and Luckmann call for a critical analysis to be upheld to reveal the ways in which individuals and groups construct their perceived social reality.

4.1.5 Rationale for the use of Social Constructionism

Social constructionism puts forward the view that daily interactions with others contributes to individual versions of knowledge. Therefore an emphasis lies on the

need to investigate how social practices exist amongst individuals to inform their perceptions and beliefs about reality and the world. In this study, social constructionism provides the opportunity to reveal how beliefs and perceptions of health occurred within a social context. The approach maintains that subjective meanings amongst individuals, such as health beliefs, can be uncovered through a critical examination of the ways in which interaction occurs with others.

This study adopts the social constructionist framework to consider how knowledge and perceptions of health have come to be created through interactions with others and the community under investigation. Therefore, it looks at the ways in which social factors such as kinship structures, peer networks and engagement with the community all contribute to the meaning-making processes for how Indian Punjabi men might perceive health beliefs related to T2D.

Social constructionism advocates the application of the critical observation of behaviour to avoid the categorisation of phenomena into pre-determined moulds. Therefore in order to examine individuals' life experiences and their perceptions of T2D, there is a need for an in-depth examination into this phenomenon. Applied to this study, this translates as the examination of how individuals talk about their lives to uncover how health beliefs and perceptions of T2D have formed within society.

In addition, risk perceptions are also embedded within individual experience of society and culture. From this perspective, risk is “never fully objective or knowable outside of belief systems and moral positions; what we measure, identify and manage as risks are always constituted via pre-existing knowledge and discourses” (Lupton, 1999; 29). In other words, risk is a social concept which is subjected to

structural forces and influences in society. This includes the reproduction of knowledge through social interaction, where meanings and inferences about reality are subject to change. Therefore, all knowledge about risk is tied to the socio-cultural context within which it is created. This reinforces the notion that risk and understandings of risk are not objective, but instead subjective interpretations which are constantly constructed and reconstructed in the process of social interaction and mean making:

“We can only ever know and experience risks through our specific location in a particular socio-cultural context. This approach to risk highlights the importance of understanding the embeddedness of understandings and perceptions of risk, and emphasises that these understandings and perceptions often differ between actions which are located in different contexts” (Lupton, 1999: 30).

Social constructionism recognises that risk construction is individualistic and context specific, and are created within differing world views. Perceptions of risk are bound to different socio-cultural contexts in which knowledge is generated. This approach is particularly important in understanding how perceptions of risk often differ between actors located in different contexts and time.

Therefore, objective facts about reality are unobtainable and perceptions of risk can only be studied as interactions which are mutually created within the inquiry between the researcher and the respondent (Guba and Lincoln in Denzin and Lincoln, 1994). Therefore, the social constructionist approach to risk is a relevant lens to adopt when the phenomenon is related to exploring people’s beliefs and judgements of risk.

The social constructionist perspective has been adopted as the theoretical lens through which risk is seen in this study in order to explore subjective perceptions of risk as concepts which have emerged from particular social and cultural contexts.

The application of social constructionism as an epistemological perspective emphasises the need to explore deeper into what is already known about South Asian health beliefs to reveal the complex details of individual lives and how individuals understand their lives to demonstrate how specific health beliefs and perceptions have occurred and why.

4.1.6 Rationale for the use of qualitative methods

The long and weighty debate surrounding the methodological differences between qualitative and quantitative approaches is not explored here due to the fact that discussions about appropriate methodologies tend to be polarised, and have been described in detail elsewhere (Baum, 1995; Hedrick, 1994; Sale et al., 2002). Methodologies are diverse and should be selected based on the appropriateness of the problem under investigation. Therefore, this section will provide a brief justification for the appropriateness of qualitative methods in this research study.

As discussed earlier, ontological assumptions about the world influence epistemology and how we understand human nature. In addition to this, epistemological positioning influences the research paradigm. The choice of research paradigms derives from two major theoretical perspectives; positivism and interpretivism. Positivism, developed in the early 19th century by Auguste Comte (1848), is the exploration of authentic knowledge based on empirical observation and is associated with scientific-

based inquiry, characterised by measurable variables and observable events (Maykut and Morehouse, 1994). Interpretivism derives from the work of Georg Simmel (1858-1918) and Max Weber (1864-1920) and encompasses the rejection of the scientific method and empiricism, and focuses on the understanding of meanings that social actions have on human beings. Interpretivism is primarily concerned with individuals in order to explore and discover social phenomena with the aim of gaining a deeper understanding of the experience of individuals (Maykut and Morehouse, 1994). Rooted in interpretivism, qualitative methods are more suited to uncovering rich meanings, values and experiences which individuals perceive. Despite various definitions existing within the literature, Denzin and Lincoln (2003) provide a comprehensive definition of the approach, which describes qualitative research as an interpretive activity which situates the observer into the world it is viewing to study things in their natural settings in order to make sense of them (Denzin and Lincoln, 2003; 5).

The qualitative approach is defined by the aim to acquire specific knowledge about human behaviour to understand individual actions and belief systems within the natural settings in which they take place. Therefore qualitative methods are usually employed for “identification, description and explanation-generation, whereas quantitative methods are used most commonly for explanation testing and control” (Crabtree and Miller, 1992; 6). Qualitative research methods are a holistic way of exploring phenomena related to human experience, which can uncover rich understandings related to an individual’s experiences and beliefs about their life world. Qualitative methods are the most appropriate choice for this research as the research questions are primarily concerned with investigating the complex meanings

individuals associate with health and T2D. In addition, Lincoln (1992) argues that there are substantial links between health research and constructionism, which invite researchers to explore new terminology used in health such as 'lifestyle' and 'wellness'. Lincoln (1992) points out that these terms are social constructions in of themselves, as they are subjective to each individual. This provides a pathway for qualitative methods to uncover the rich meanings people ascribe to their definitions of health and illness. The application of qualitative methods in social research is particularly appropriate when the research is located within the subjectivist end of the subjective-objective continuum (Morgan and Smircich, 1980). The following describes the qualitative approach adopted in this study and the justification of this method.

4.1.7 Narrative inquiry approach

As previously mentioned, qualitative research focuses on the meanings individuals ascribe to their lives, as opposed to the search for objective factual truths (Denzin and Lincoln, 2003). This is supported by the social constructionist position, where reality is seen to be constructed by individuals and therefore we are only able to access interpretations of realities. One way of accessing some of these interpretations is through narratives and storytelling. The narrative inquiry approach was selected due its potential to reveal human action and experiences of an individual's engagement in the social world through storytelling (Polkinghorne, 1995). Applied to health research, the narrative inquiry approach has emerged as a reliable method in the exploration of experiences and meanings of health amongst individuals

(Greenhalgh and Hurwitz, 1999; Mishler, 1986; Williams, 1984; Mattingly, 2000; Hyden, 1997; Bury, 1982).

Narrative data can be collected through a variety of means such as audio, video recordings or diary extracts, however narrative interviews are most commonly employed (Elliot, 2005). The narrative inquiry approach is characterised by the narrative interview, which is a specific social interaction in which a narrator tells their story (Kleinman, 1988). Researchers are granted access to individual life experiences and meanings such as memories, beliefs, attitudes and perceptions through the stories individuals tell. The narrative inquiry approach is a useful method to view the life world of the individual: “narrative is treated as a distorted mirror held up to the world in motion, held up by storytellers to reflect reality as it approaches, passes them and recedes into the distance” (Laurier, 1999: 192). Whilst allowing researchers access to individuals’ grounded experiences, the approach also has the capacity to “preserve and guarantee the integrity of the life and the experiences of the life world” (Atkinson, 1997: 332).

The narrative inquiry approach produces a specific form of data in which “memory, experience, time and biography are constituted through conventional acts of narrating” (Atkinson, 1997: 327).

The nature of narrative interviews can be likened to those approaches adopted by ethnographic methods. Narrative interviews function as a departure from structured interviews by allowing respondents to engage in storytelling. This is a distinct departure from the traditional ‘question and answer’ format. In addition, it is a

discursive accomplishment in the ways in which talk occurs collaboratively between the interviewee and the researcher (Mishler, 1984; Rapley, 2001).

The narrative interview is traditionally characterised by long sections of talk, in which detailed accounts of individual life experiences are given. Narrative interviews have the potential to identify past experience and place them into a temporal order (Riessman, 2008). Viewed as an interactional tool, the nature of the narrative interview differs from the traditional conversation style as it requires the participant to take a longer turn talking (Riessman, 2008). Riessman (2008) highlights that in order to acquire the extended narrative, it is in the researcher's interest to surrender control: "narrative interviewing necessitates following participants down their trails" (Riessman, 2008: 24).

Whilst there is no specific guidance on the appropriate number of narrative interviews which should be conducted, the end of the data collection process is usually established at the point in which theoretical saturation occurs (Glaser and Strauss, 1967; Guest et al., 2006). Theoretical saturation refers to the monitoring of the development of a theory, and occurs when all of the variations of a phenomena have been identified (Sandelowski, 1995; Guest et al., 2006).

The application of the narrative inquiry approach in this study is based on the notion that reality and experience occur within a narrative structure (Riessman, 2008).

Gergen and Gergen (2003) argue that the narrative structure informs and contains individuals' lives "because we are treated by others as storied characters we are often called upon to 'tell a story', to recount our past, to identify where we have been and where we are going" (Gergen and Gergen, 1999: 70).

The emphasis on the importance of multiple realities amongst the social constructionist perspective maintains that individuals hold subjective personal stories which detail different versions of reality. Here, more than one reality exists and can be seen to be constituted as originating from individual experience and narrative stories are considered as a way of explaining human behaviour. As meaning is constructed through interaction, narrative is seen as the way in which individuals make sense of the world (Murray, 2000). The narrative inquiry approach is inherently connected to the social constructionist perspective in the way it can be utilised to open up the meanings individuals ascribe to health beliefs to reveal the influences on those perceptions.

Narratives are therefore shaped and created by the perspectives of those who tell the story and social constructionism acknowledges the ways in which perspectives occur in the interpretation of social phenomenon.

The way in which the narrative inquiry approach functions to reveal the experience of an individual's life makes it suitable to the aims of this research project: to explore the perceptions related to health and T2D. Due to the fact that this study is primarily concerned with the exploration of the individual life world, and the social and cultural context in which the story unfolds, the narrative inquiry approach was deemed as the most appropriate method for exploring how individuals spoke about health beliefs. This method also had the potential for individuals to reveal their health experiences via stories, to provide context to allow for wider interpretation for other factors which influence beliefs and perceptions such as culture and social influences.

4.1.8 Summary

This section has provided a background to the epistemological and ontological framework of this study, and how this has informed the narrative inquiry approach which was selected due to its appropriateness in exploring human functioning through listening to the retelling of experiences. The next section describes the methods selected, and includes descriptions of the sample design, recruitment, data collection and analysis.

4.2 Methods

4.2.1 Introduction

The aim of this study is to explore the social and cultural factors which influence health beliefs and perceptions of risk of T2D amongst two generations of Indian Punjabi men. In order to meet this aim, two objectives need to be addressed:

1. To identify and explore the specific cultural and social practices which shape Indian Punjabi men's health beliefs.
2. To explore how the risk of T2D is perceived amongst Indian Punjabi men.

I have chosen to write this chapter in the first person as a rhetorical device to reinforce my authentic voice as the researcher of the project, which keeps in line with the epistemologies of the research (Webb, 1992). Use of the third person is traditionally a neutral position and therefore not appropriate for this chapter which explores the social elements of the research processes and I would be in danger of

excluding myself from the research processes such as sampling, conducting interviews and analysing data.

The study is based on twenty-four narrative interviews conducted with Indian Punjabi men: eleven first generation migrant men, and thirteen second generation men. First generation migrants are defined here as individuals who migrated from India to the UK. The second generation are defined here as those who were born in the UK whilst having parents originating in India.

As stated earlier, the criteria were predetermined due to the fact that Indian Punjabi men have not been extensively researched as an exclusive group within the field of T2D health research. I sought to recruit men who would be willing to talk about their life experiences in relation to health and T2D. Participants met two criteria: (1) they were over the age of eighteen and (2) they originated from an Indian Punjabi background. Both first and second generation men were included as I was keen to identify any differences and/or similarities between the groups. Table 6 provides a descriptive summary of the research aims, objectives, methods and the sample:

Table 6. Descriptive summary of the research

Objectives	Sample	Method	First Generation N =	Second Generation N =
To identify and explore the specific cultural and social practices which shape Indian Punjabi men's health beliefs To explore how the risk of T2D is perceived amongst Indian Punjabi men	First and second generation Indian Punjabi men	Narrative Inquiry	11	13

4.2.2 Sample design and entry to the field

This section describes the recruitment process which consisted of two approaches. I began by attempting to recruit members in a local south Asian community in Birmingham via local gatekeepers such as religious and community leaders, which proved to be largely unsuccessful. This led me to redevelop my recruitment strategy. In the second approach, I utilised my own personal contacts to identify key informants who facilitated the recruitment of all of the participants. The following describes some of the difficulties I encountered whilst trying to gain access via local gatekeepers, and the justification for using key informants in recruiting the sample population.

4.2.3 Recruiting via gatekeepers in the local community

Birmingham is home to a growing population of Indians, with over sixty-four thousand living in the region (Census, 2011). I chose to recruit in an inner city area of Birmingham that is a highly densely populated area with many different minority ethnic groups, and home to a large Sikh community, with a number of Gurdwaras and Sikh community centres (Birmingham City Council, 2013).

After deciding on the inclusion criteria, I chose to recruit participants via gatekeepers in the local community, who were religious priests in Gurdwaras and local community leaders. This method has been identified by qualitative researchers as an appropriate method of recruiting ethnic minority members (Sheikh et al., 2009).

I contacted these organisations by telephone. I acquired the telephone numbers from the internet and the local phone directory. By contacting the organisations in this way I aimed to speak to managers and priests to inform them about my role as a researcher and the aims of this project.

However, contacting organisations via telephone resulted in a number of obstacles which prevented the recruitment of any participants. For example, it was a challenge to obtain correct telephone numbers for the organisations I wanted to contact. This often resulted in reaching a wrong number or a dead line. Problems continued even when I was able to contact the correct places, as it was difficult to identify and speak with gatekeepers. On many occasions, community leaders or priests were often absent at the time of my call. I left messages with various individuals, but these were not returned.

Despite these challenges, I had managed to speak to two priests at two different Gurdwaras. The two priests expressed their willingness for me to visit the Gurdwara to display research posters and leaflets, but seemed wary of me recruiting participants. One priest spoke of his concerns surrounding the willingness of community members to talk to me about health issues, stating that people would feel uncomfortable talking about their health. The second priest expressed similar concerns and spoke of his unavailability and time constraints due to the busy schedule of the Gurdwara. As a result, this process revealed itself to be both time consuming and unsuccessful.

I proceeded to display research posters and leaflets in these two Gurdwaras. The posters and leaflets advertised the research to possible participants, which included a brief description of the research and my contact details. After a period of three weeks I did not receive any responses. This then led me to extend the places in which I was displaying the posters and leaflets. Since I was also interested in recruiting second generation participants, I decided to place the materials around the campus of the University of Birmingham after receiving appropriate ethical clearance from the university's ethical review panel. This was done in an effort to recruit south Asian men over the age of eighteen who might be interested in participating. Nevertheless I received no responses.

It could be argued that these challenges might have been overcome if I had a direct link with those located in the community. Building a relationship may have facilitated trust with gatekeepers who might have been more receptive towards the research. For example, it has been cited that gatekeepers in organisations can sometimes be suspicious of the motives of researchers (Flick, 2009). In addition to this, it should be

noted that accessing organisations and institutions remains inherently problematic. For example, participation is time consuming and can be seen as a disturbance to the routine of the organisation.

The methods I had employed to recruit members of the community proved to be a messy and unsuccessful process. The failure of this approach ultimately led to the renegotiation of the recruitment strategy. The first failed attempt at recruitment compelled me to rethink how I was going to access the Punjabi community. This led me to reflect about my own identity as a fellow Indian Punjabi and how I was connected to the community.

The following describes the second technique I employed to recruit participants: the use of personal contacts and key informants. This involved drawing upon my own background and identity to locate key informants and participants.

4.2.4 Recruiting through key informants

As a British born Punjabi Indian, I have heritage to the Indian Punjab through my parents who are first generation migrants. After their migration to the West Midlands in the 1960s, they established themselves in the social network with other Indian Punjabis in the Sikh community. This was largely down to their attendance of Gurdwaras and community functions. As a result, they became well known within their local Indian community.

I recognised that my parents could be enlisted as key informants as they were established members of the community who had access to individuals who could

participate in the research and recommend others. Key informants are individuals who “possess special knowledge, status or communication skills, are willing to share their knowledge and skills with the researcher and have access to perspectives or observations denied the researcher” (Gilchrist, in Crabtree and Miller, 1992; 75).

Some of my parents’ contacts were established members of the south Asian community within Birmingham with links to others. For example, one participant worked as a youth leader in a community centre and recommended my research to others.

I employed my parents as key informants for pragmatic reasons, as I could not simply locate participants alone. In addition, utilising key informants proved to be an efficient way of locating participants within the time constraints of the research project. In addition, it is important to note that I actively chose my parents as key informants based on their ability to access those who were representative of the sample.

Snowball sampling was utilised as the primary recruitment method. Snowball sampling is defined as “a non-probabilistic form of sampling in which persons initially chosen for the sample are used as informants to locate other persons having necessary characteristics making them eligible for the sample” (Bailey, 1994: 438). This approach relies on the recruitment of participants via other informants where one person gives the name of another participant (Vogt, 1999).

Authors have advocated the use of snowball sampling when conducting research with ethnic minorities and hard-to-reach groups (Faugier and Sargeant, 1997, Hughes et al., 1995; Adamson and Donovan 2002; Penrod et al., 2003), and the need for a variety of recruitment strategies to ensure the recruitment of ethnic

minority groups. Importance is also placed on the need to develop personal relationships with gatekeepers and organisations to facilitate recruitment (Adamson and Donovan, 2002).

My parents initiated contact with individuals via the telephone, and provided a brief overview of the research and the interview procedure. Verbal consent was then given over the phone, and time and place for the interview was agreed. Formal consent was also obtained in the form of a participant information sheet (see Appendix 1) and the signing of a consent form (see Appendix 2). Obtaining valid informed consent is a crucial part of conducting ethical qualitative research (Bulmer, 1982; Guillemin and Gillam, 2004; Flick, 2009). It refers to two ethical questions: does the participant in the research fully understand the project? And how do the risks involved compare to the potential benefits, of the study (Homan, 1991). It is widely accepted that participants in a research study must have an understanding about the study, understand the voluntary nature, have knowledge of the general purpose of the research, and understand any risks or consequences that may be involved in participation (Homan, 1991).

Gaining informed consent ensures that the participants are given adequate information that allows them to make the decisions about the risks and benefits of potential participation (Larossa et al., 1981). In addition, it is a requirement that participants have access to written information about the study to ensure informed consent. Therefore, I created a participant information sheet (PIS), which was designed to inform the participant about the research, invite the participant to take part, inform the participant how data would be collected and how confidentiality would be ensured. In addition to this, the PIS also included background information about

myself and details of the institution that was funding the research project. The purpose of the PIS was to provide an overview of the research for the participants to obtain all of the facts necessary prior to gaining consent. The PIS was created in conjunction with the consent form. Participants were asked if they understood the PIS and if they had any questions in regard to the study. It was only when the participant was satisfied with the information that they were asked to sign the consent form. The consent form asked for confirmation of understanding five aspects of the study: that the respondent had read and understood the PIS; that the respondent had had an opportunity to ask questions; that participation was voluntary; that an agreement to participate in the study meant quotes from the interview might be used in publications at a later date. An agreement of a summary of findings was to be sent on completion of the study.

4.2.5 Summary

Attempting to gain access to the Indian Punjabi community using these methods proved to be a difficult task. It became apparent that approaching gatekeepers via the telephone inhibited recruitment, which might have contributed to how I was perceived as an 'outsider'. Instead, utilising key informants who had links to others became a useful way of approaching participants located in the community. In these instances, I was known to the participant through my parents, which might have facilitated recruitment through my identity as an 'insider'. The implications of my identity on the trustworthiness of this study will be explored later in this chapter.

4.2.6 Sample size

The aim of qualitative research focuses on the exploration of social processes, as opposed to being representative of the larger population (Kuzel in Crabtree and Miller, 1992). Therefore the majority of qualitative sampling strategies aims to identify a specific group who closely represent the social phenomenon being investigated (Mays and Pope, 1995).

Qualitative research that employ interviews aim to explore the social life and multiple realities of its participants, meaning researchers need to be immersed in the research field to address the research problem (Crouch and McKenzie, 2006). Therefore, a smaller sample is advantageous in allowing the researcher to get closer to the participants to enhance in-depth inquiry in naturalistic settings (Crouch and McKenzie, 2006).

Therefore a purposive sample was utilised to determine the sample size of thirty participants. The aim of qualitative research which employs purposive sampling aims to continue the sampling process until theoretical saturation occurs (Glaser and Strauss, 1967, Guest et al., 2006). Saturation was achieved in this research study through the documentation and recording of the progression of the themes during data collection and analysis. Twelve interviews were conducted prior to coding (six first generation participant interviews and six second generation participant interviews). The codes and themes for these interviews were then reviewed for the purpose of identifying new emerging data. After six more interviews (three first generation participant interviews and three second generation participant interviews),

no new significant data appeared to be emerging from the analysis. However, another six interviews were conducted (two first generation participant interviews and four second generation participant interviews), at which point no new data emerged.

4.2.7 Narrative interview design

The narrative interview was designed to illuminate a personal narrative which is characterised by large sections of talk about the individual's life experiences (Riessman, 2008). To facilitate the beginning of the narrative, the interview began with a 'generative narrative question', which is designed to encourage the beginning of the participant's main narrative (Flick 2009). I had chosen to use a generative narrative question that encompassed the aim of the interview: to capture the life story of the participant:

"Could we start by you telling me about your life, from childhood to the point you are at now?"

It was important that I did not interrupt the flow of the narrative once it began in order to maintain the quality of the data. Therefore during the opening narrative, I took notes and gave non-verbal acknowledgements.

The end of the main narrative became apparent through certain statements or phrases that signified the end of the story (Flick, 2009). After this, I probed the participant for further information from the main narrative which were omitted or lacked detail. I asked questions to inquire further to find out more. For example:

"Could you tell me more about X and Y and how it made you feel?"

“Could you tell me what happened after X occurred?”

4.2.8 Data collection

Before the beginning of each interview, I prepared myself by reading the PIS and the consent form to remind myself of the research aims and objectives. This helped me to talk to the participants about the research process with ease and confidence.

I chose to present myself in casual dress for the interviews. I could have chosen to wear traditional Punjabi dress, such as a salwar kameez. The salwar kameez is a popular style of dress worn by Punjabi women which comprises of a long tunic top, loose fitted trousers and a scarf. However, I chose not to wear a salwar kameez as I felt that by wearing one I would have presented myself too formally for the setting of the interview. This instinct was largely based on the fact that the majority of the participants were accustomed to seeing me in casual dress, and had only seen me in traditional dress in formal settings such as weddings. Therefore, I was concerned that by dressing traditionally for the interviews, I would have unintentionally created a formal setting which may have affected how the participants opened up to me. Therefore, I felt it was appropriate to dress casually for the interviews as they were being held at the participants' homes and not in a formal setting.

In addition, I was conscious of not presenting myself as an academic researcher, but instead as a family member. This was particularly important as it has been recognised that bodily appearances impact on the researcher's identity and how they are perceived by participants (Ellingson, 2006; Okely, 2007) and therefore it is important to carefully consider and manage these. I felt it was particularly important

to reduce the level of formality, and to create openness to facilitate rapport. However this was particularly easy to do since many of the participants knew of me through my parents.

The interviews began with me introducing the study to the participants. This introduction highlighted the main points from the PIS. After this, many of the participants began talking about the study and shared their opinions about T2D before the interview began. By introducing the research in this way, I was able to contextualise the study for the participants which helped facilitate the commencement of the interviews.

The interviews took place at the participants' homes, and lasted between fifty and ninety minutes. Data was collected via a digital voice recorder. A digital voice recorder was used so that the data produced in the interview could be recorded accurately and transcribed verbatim. After each interview, the digital audio file was transferred on to my personal hard drive. This was password protected and only accessible by myself.

Transcripts were cleaned up to remove inaudible utterances, interruptions, pauses and repetition. All of the participants responded in English, but some of the first generation participants spoke Punjabi intermittently. I was able to understand these words due to my shared cultural identity with the participants, which facilitated translation. Nevertheless, I translated the Punjabi words as close to English as I could since some Punjabi words have no direct English translation.

Respondents were anonymous during the study as names of individuals, specific personal details and identifiers were removed and/or changed during data analysis.

Procedures were also put in place to ensure confidentiality. For instance, during data collection, electronic data was not accessible to others without prior permission. In addition, raw data in the form of voice recordings were stored on my password protected hard drive. Data transcriptions were also only accessible to me and my supervisors.

4.2.9 Methodological rigour

As in quantitative research, a similar strategy is applied to ensure rigour in qualitative research, which includes the 'systematic and self-conscious research design, data collection and interpretation (Mays and Pope, 1995: 11), and attends to validity and reliability.

An aspect of rigour is validity. Within the positivistic framework, validity is associated with established techniques common to quantitative methods, whereas in qualitative research, validity is referred to as 'trustworthiness'. Lincoln and Guba (1994) describe trustworthiness as the believability of the researcher's findings. Within this research, I have sought to achieve trustworthiness through a number of techniques in order to make the research process visible to others. This was primarily done through an audit trail. The audit trail consisted of documenting the methods of data collection and analysis. This included a detailed description of the research process, the recruitment process, procedures of data collection and analysis. This also included keeping a researcher's diary, original interview transcripts and field notes.

Reliability refers to the methods used to ensure the reliability of the data analysis through the collection of raw data such as transcripts and interview notes (Mays and

Pope, 1995). The reliability of this study was enhanced through the use of colleague review. After the data analysis had taken place, I had asked fellow peers to read some of the data transcripts and review my coding framework. This procedure is described in further detail in this chapter under the heading 'Coding process'.

4.2.10 Ethics

This research project complied with the University of Birmingham's ethical guidelines and guidelines from the UK Research Councils. It was not necessary to seek ethical approval from the National Research Ethics Services (NRES), as the research did not meet the following circumstances: clinical research involving NHS patients, accessing NHS patient data, the collection or use of NHS patient data, researching NHS health-care professionals, or using NHS premises.

4.2.11 Reflexivity

It is important to attend to the issues surrounding reflexivity within this study as it is central to qualitative research and the use of interviews as a method of data collection (Mauthner and Doucet, 2003). Reflexivity invites qualitative researchers to bring to light their own experiences, beliefs and feelings during the research process (Finlay, 2002). The main purpose of maintaining a reflexive account is to help the researcher be aware of the possibilities of biasing which may influence the interpretation of the data (Ahern, 1999). Reflexivity is particularly important within the context of the narrative interview setting, where meanings are jointly constructed between the respondent and the researcher, who contribute to the narrative

production (Enosh and Buchbinder, 2005; Holstein and Gubrium, 1995). Therefore, it is necessary that I explore my role within the context of this research study by reflecting on my experiences and exploring how any personal biases may have affected the quality and truthfulness of the data I collected. It is also necessary that I address how having a previous relationship with the participants may have influenced the research process.

As an Indian Punjabi female who knew some of the participants personally, I acknowledge that I had some preconceptions which may have influenced how I conducted the interviews and how I initially perceived the group I was studying. Coming from an Indian Punjabi background myself, I had some preconceived ideas about what the men would be willing to talk about. For example, I presumed that they would want to talk in-depth about alcohol consumption within the Indian community. This preconception had risen from my own personal experiences from being in social settings and witnessing for myself the extent to which alcohol is consumed by Indian men. On reflection, this may have influenced how I approached the topic of alcohol consumption in my questioning, as I may have placed more emphasis on that topic more than others.

In terms of how I perceived the group prior to data collection, I had anticipated that the men would not be forthcoming in talking about health related issues. This presumption came from reading the literature around masculinities and health, which positioned men as being typically less engaged with their personal health compared to women. However once I started interviewing the participants, I was surprised by the degree of openness with which they had shared their own and other people's

health experiences. On reflection, I believe my presumption may have facilitated the flow of the discussions as I had not been expecting to hear as much detail as I did.

As I was known to the majority of the participants, it is important to highlight the effects of a previous relationship between researchers and participants in the processes of data collection. Garton and Copland (2010) discuss the effects of a previous relationship on the development of rapport. The authors refer to 'acquaintance interviews' to describe semi-structured interviews conducted when the researcher is an insider and a prior relationship exists between the interviewer and the interviewee (Garton and Copland, 2010). As talk takes place within a symmetrical frame amongst friends and family in a non-research setting, this frame is negotiated to become asymmetrical as the aim of the talk changes (Garton and Copland, 2010). Highlighting the effects of prior relationships on the interview process further emphasises the fact that achieving interviewer neutrality becomes unlikely as the interview takes place within a context where the respondent and the researcher share a history (Garton and Copland, 2010). As a result, the narrative interviews took place within a similar context, as talk was actively managed due to the existence of a previous relationship. For instance, some participants enquired about the formality of the interview process prior to its commencement.

As well as addressing the effect of my personal biases and a previous relationship, it is also important that I address some of the wider issues associated with this type of interaction. In the following section I provide a reflexive account of my experience interviewing Indian Punjabi men. I begin by describing my identity and exploring the similarities and differences which existed between myself and the participants and

how they may have influenced the research and findings. I also discuss the use of nonverbal cues, and how I managed the risk of coercion during the interviews.

4.2.11.1 Reflexive reflections

I was born and raised in a multicultural city in the West Midlands. My parents were born in the Punjab and lived there until they reached adulthood, and migrated to the UK in 1965. My siblings and I were raised in a liberal home, and we adhered to traditional Punjabi religious practices, which saw us worship at Gurdwaras. Being Indian Punjabi myself, I shared the same ethnic identity and cultural background as the participants in this study. In the following section I explore the effect of these similarities on the interview process and how they may have influenced the findings. For example, being Indian Punjabi influenced how they identified me as someone who was 'one of them'. This became particularly evident when some of the participants described social phenomena related to the Indian Punjabi community, they often used phrases such as "you know what I mean"/"you know how it is". I felt that the participants perceived me to be a fellow community member or an 'insider', as opposed to a professional researcher or 'outsider'. Insider status refers to ways in which I was seen to be a person who was known to the respondent and a person who shared the same ethnic and cultural background as them, such as ethnicity, language and social and cultural knowledge (Merton, 1972). Feminist authors have identified the benefits of researchers who share similar characteristics to their participants such as gender, race and ethnicity (Finch, 1993; Coffey, 1999; Lee, 2008). However, being an 'insider' may have had disadvantages. Whilst I may have

been knowledgeable about certain social phenomena compared to a non-Indian Punjabi researcher, I may have been biased in my questioning due to my own life experiences. In addition, interviewing from an insider status does not guarantee rich data or more reliable data in comparison to those studies where the researcher is unknown to the respondent. This is due to the fact that possessing an insider researcher status is also complex (Bhopal, 2010).

While sharing the same ethnic identity and cultural background as the participants may have facilitated rapport, I was conscious of minimising the influence of my identity on the findings. For example, I was aware that I needed to ask the participants for clarification when they made assumptions about my 'insider' knowledge. By doing this, I invited the participants to explain phenomena in their own words by asking them to "tell me more", in order to avoid my own interpretation influencing the analysis and findings.

However, I did not share all of the same characteristics with the participants as we differed in gender and age. In the following section, I discuss the implications of the gender and age difference between myself and the participants on the research and findings. The influence of gender on the interaction between researchers and participants has been featured in the literature (Bell et al., 1993; Broom et al., 2006). Reflecting on the gender and age difference between myself and the participants, I believe it had both positive and negative influences on the research process and findings. On the one hand, I felt that my gender and age helped to create a close bond between myself and some of the participants, particularly those of the first generation. This was exemplified by how they referred to me as 'beta', a Punjabi expression used to address younger women as a daughter or niece. Being called

‘beta’ by some of the men reinforced my identity as an insider, and I was made to feel like a family member. It was in this way that my gender and age helped facilitate a close relationship with the older men, which created a level of openness and mutual respect.

However, it is important to acknowledge that the gender difference between myself and the participants may have contributed to the omission of some findings. This is mostly to do with how my gender may have influenced how some of the men may have felt inhibited to talk about certain topics. For example, some of the men may have felt uncomfortable discussing intimate details about their lives. However, it is difficult to distinguish whether my gender or my age was the barrier as it would have been culturally inappropriate to discuss topics related to sexual health and personal relationships. My gender may have also influenced how some of the participants voiced their opinions about women during the data collection. For example, during the interviews the topic of women’s roles in food preparation and homemaking was discussed. It could be assumed that because I was a woman, the men may have altered their responses in order to avoid offending me. This would have had an impact on the findings as I might not have been able to collect accurate opinions about these topics. Isolating the specific parts of my identity which influenced the findings is difficult to determine. However, a comparative study using a researcher of the same gender but different ethnicity could reveal any differences in the data collection. In addition to addressing the impact of my identity on the research process, I also explore some of the wider issues related to risk and power in the following section.

It is accepted that there is a risk of coercion associated with unstructured interviews such as narrative interviews, especially when the topic of research may be considered sensitive in nature (Corbin and Morse, 2003). This is due to the fact that participants are invited to share their stories which involves sharing personal information about their lives (Corbin and Morse, 2003). As the participants were already known to me, this may have presented a risk in how some of them may have felt obliged to participate. In addition, they may have been more prone to sharing information unwittingly. I was also aware of the fact that the participants may worry that I may inform others in our shared circle of friends/family about what they had told me.

I became aware of these issues during the data collection stage of this study, and adapted my approach in order to reduce this risk. For example, I was mindful of the power status which existed between myself and the participant, in which in traditional interview settings, the researcher can be considered as either exerting power over respondents or empowering respondents by inviting them to talk about their lives (Hoffmann, 2007; Corbin and Morse, 2003). I also adapted my interview approach so that I was unobtrusive in my questioning, giving the participant control of what and how much was shared. Nevertheless, I was not completely devoid of power. I possessed some power as I was the researcher and although the narrative interviews were largely directed by the respondents' stories, the interviews existed within the context of the wider aims of the research and therefore it was not entirely non-directive. I also sought to continually reassure the participants that their contributions were being made in strictest confidence.

It is also important to reflect on the non-verbal cues which occurred during the interviews, including silence and facial expressions, which were removed from the analysis as part of the transcription process. Fivush (2010) conceptualises silence as socially constructed within conversational interactions, and attributes various meanings to silence within the context of the spoken narrative. Reflecting on my own experiences, silence occurred on various occasions during the interviews. The participants usually became silent at the end of their main narrative, which I interpreted as the end of their storytelling. There were also times when I was silent, particularly when participants were speaking in length about a subject. During these times, I felt it was appropriate to be silent for two reasons; so I did not impinge on their speaking and to show that I was being attentive and listening observantly. This was also reinforced by my facial expressions. I found myself frequently nodding in agreement with the participants and maintained eye-contact. On reflection, I felt that I used these cues as a way of maintaining a mutual interaction with the participants without disturbing the flow of talk.

4.2.12 Analytical framework

Thematic analysis was employed in this research project (Boyatzis, 1998). Thematic analysis functions as a way of identifying common concepts and themes across individual contributions in an attempt to understand the phenomenon under investigation. The focus of thematic analysis is primarily concerned with the content of what is said. Codes were applied to the data using the CAQDAS (computer assisted qualitative data analysis) programme, NVivo (Richards, 1999).

4.2.13 Coding process

Coding is a method of analysing qualitative data which has the capacity to reveal meanings from the data (Coffey and Atkinson, 1996). In this study, the primary aim of coding was not to quantify the data but to instead uncover meanings embedded in the data (Brent and Slusarz, 2003). The procedure of coding utilised in this study draws upon guidelines suggested by Saldana (2009). Thematic coding was referred to as a tool highlighting the social distribution of perspectives within a phenomenon (Flick, 2009). This was characterised by the process of a close analysis of the transcription, whilst maintaining a constant query of the overall meaning of the data.

This process involved the individual analysis of transcripts before incorporating data together. Transcripts were read on numerous occasions in order to gain familiarity with the data. During this process, codes were applied to significant segments of data. This was a multi-step procedure that involved line-by-line analysis. This resulted in the collection of codes which I felt best described the meaning within the data.

During this stage, patterns of similarity which occurred across the codes were recorded in note form to highlight likeness with other codes for the purpose of theme generation. Table 7 provides an example of how codes were ascribed to data:

Table 7. Coding the data

Data	Codes
<p>“And also we suffer from unnecessary tension. Stress, we worry too much about our families or sons and we don't realise that once they are adult they have to stand on the own feet but we keep protecting them. And worry about them and when we know they're not fit for marriage but were married off anyway and create another problem. Then we worry about our daughters. If we have two or three daughters to marry them off it's a huge debt I can't imagine any wedding costing less than £20,000.” (First Generation, Participant 4)</p>	<p>Indian people seen as suffering collectively</p> <p>Stress</p> <p>Worry</p> <p>Parental responsibilities</p> <p>Impact of financial strains</p>
<p>“Now...that kind of physical hard work is almost disappearing but eating habits are still the same (there and here) for some of our people” (First Generation, Participant 8)</p>	<p>Food eating habits</p> <p>Impact of physical work</p> <p>Challenges seen in changing food habits</p>

This process continued for each individual transcript. Codes were then grouped together and compared across transcriptions to reveal patterns of similar codes across the data. These codes were then placed together under a ‘category’ which housed codes which shared similar characteristics. Table 8 demonstrates how codes were grouped into categories:

Table 8. Sorting codes into categories

Codes	Category
Awareness of health and education Education and awareness Influence of medication and education Improving facts and information	Importance of health awareness via education

Theoretical coding was applied at this stage with the aim to group together similar categories of codes in order to “integrate and synthesise categories derived from coding and analysis to create theory” (Saldana, 2009: 164). This process involved categories being grouped together in accordance of their similarity which in turn created ‘themes’.

In order to maintain trustworthiness throughout this process, the codes were reviewed and checked by my academic supervisor (Dr Sabi Redwood) who examined the codes and categories on Nvivo. Due to her in-depth knowledge and experience analysing qualitative data, she was able to review the codes and check for consistency. A selection of the transcripts and codes were also peer reviewed by a fellow south Asian doctoral researcher who read and independently coded some of the transcripts in order to enhance reliability. We met to discuss his conclusions, and it became apparent that the majority of the codes were similar and only a few codes were different. However, we discussed these differences and explored possible alternative interpretations. By doing this, I was able to develop a broader understanding of other interpretations, which informed the rest of the analysis.

4.2.14 Summary

This chapter has described the methods used in this research study. This included a detailed description of my reflexive position in the research process, which made my role in the research transparent. The next chapter presents the findings from the research.

CHAPTER FIVE: FINDINGS

5. 0 Introduction

The demographic details of the participants are presented in Table 9. The participants came from a number of areas within the West Midlands, including Walsall, West Bromwich, Great Barr and Sandwell.

Table 9. Participant demographics

Demographic information	Number of participants
First generation	11
Age range	45-71
Occupation	Retired (6), Teacher (1), Service worker (4)
Religion	Sikh (10), Hindu (1)
Caste	Jat (8), Tarkhan (2), Ravidassia (1)
Marital status	Married (11)
Second generation	13
Age range	19-37
Occupation	Student (4), Professional (5), Service worker (4)
Religion	Sikh (11), Hindu (2)
Caste	Jat (11), Ravidassia (2)
Marital status	Single (10), Married (3)

From the initial analysis of the data, nine sub-themes emerged from the data set. These themes were then reviewed and collapsed where repetition and similarities occurred. This led to the creation of four main themes, which are presented in Table 10.

Table 10. Theme generation

Initial themes	Four main themes
<p>Describing the experience and journey of migration</p> <p>The Indian Punjabi drinking culture</p> <p>Religion and health</p> <p>Perception of self health and risk</p> <p>Indian Punjabi identity</p> <p>Attitudes to food and diet</p> <p>The role of education in improving health</p> <p>Inequality and patriarchy and the implications for health</p> <p>Recognition of generational differences in values, attitudes and beliefs</p>	<p>Perception of health</p> <p>Socio-cultural context of food and alcohol</p> <p>Health risks and place</p> <p>Risk perception</p>

This chapter explores the four main themes and is divided into two parts. The first part explores all of the themes which both the first and second generation spoke about. Part two describes the themes that were spoken about only by the first- or by

second-generation participants. Table 11 shows the themes and subcategories which are explored in this chapter for both first and second generation participants.

Throughout this chapter the data from both groups of participants will be addressed separately so that comparisons can be clearly distinguished between the groups.

Table 11. Participant themes and sub themes

First generation	Second generation
<u>Part One</u>	<u>Part One</u>
<ul style="list-style-type: none"> • Perception of health: <ul style="list-style-type: none"> ○ Individual perception of health ○ Collective perception of health ○ Excessive alcohol consumption ○ Food and diet • Socio-cultural context of food and alcohol <ul style="list-style-type: none"> ○ Food and social identity ○ Alcohol consumption • Health risks and place <ul style="list-style-type: none"> ○ Pre-migration India and health ○ Life post migration and health • Risk perception (I) <ul style="list-style-type: none"> ○ Characteristics ○ External factors • Risk perception (II) <ul style="list-style-type: none"> ○ Perceptions of family illness and risk awareness 	<ul style="list-style-type: none"> • Perception of health: <ul style="list-style-type: none"> ○ T2D and general health ○ Age and health ○ Food and alcohol ○ Collective health • Socio-cultural context of food and alcohol <ul style="list-style-type: none"> ○ Alcohol and social settings • Health risks and place <ul style="list-style-type: none"> ○ University life and health • Risk perception (I) <ul style="list-style-type: none"> ○ Characteristics ○ External factors • Risk perception (II) <ul style="list-style-type: none"> ○ Perceptions of family illness and risk awareness
<u>Part Two</u>	<u>Part Two</u>
(First generation only) <ul style="list-style-type: none"> ○ Raising health awareness/learning in the family 	(Second generation only) <ul style="list-style-type: none"> ○ Exercise, football, drugs and smoking

The narratives in this research project were collected as the respondents told them in the research setting (Riessman, 1993). The stories which emerged were characterised by in-depth and complex details about individual life experiences. Analysis of these narratives allowed for theoretical judgements to be made about the ways in which health beliefs are formed amongst the sample. These interpretations revealed the network of social and cultural influences on health beliefs and perceptions.

The following section will describe the findings from the study. In this section, the terms 'few' and 'some' have been used to give some clarity about the frequency of a theme (Sandelowski, 2001).

5.1 Part one

5.1.1 Perceptions of health

This first section explores both first- and second-generation participants' perceptions of health, which pertained to attitudes, beliefs and knowledge they held in relation to health. All of the participants spoke about their perceptions of health and risks to health, which consisted of a wide range of attitudes and beliefs related to T2D and health in general. They spoke about health and risk in two ways: individually and collectively. Individual perceptions of health and risk referred to how the men spoke about their own experiences of health and illness. Collective references described their perceptions of the health of others, namely the Indian Punjabi community as a whole. This chapter will begin with both of the groups' discussions on individual perceptions of health, and then move on to explore their perceptions of the health of

the collective community. Table 12 summarises the topics which will be covered in this chapter.

Table 12. Data summary: Perceptions of health

	First Generation	Second Generation
Perceptions of health	Individual perception of health Collective perceptions of health <ul style="list-style-type: none"> ○ Excessive alcohol consumption ○ Food and diet 	Individual perception of health <ul style="list-style-type: none"> ○ Age and Health ○ Food and alcohol

- Individual perception of health

First-generation participants

The majority of the first-generation men did not talk about their personal health, and did not talk about T2D or the potential of developing T2D themselves. When describing their health status, participants referred to themselves as being ‘OK’. When asked to talk about T2D, some admitted that they did not think about the condition:

“No not for myself, because it doesn't enter my thinking of what I eat or what I cook and not the prevalence of T2D” (First Generation, Participant 9)

One participant dismissed T2D as risk to his health due to the fact that he had a balanced diet and exercised regularly:

“does it concerned me? No because I do the best I can because I have a pretty reasonable diet and a pretty reasonable exercise regime. And in my opinion I’m pretty much OK. And I don’t have or do things to excess, so everything in moderation”

(First Generation, Participant 8)

Some of the men spoke about how they preferred to manage their health themselves, without seeking advice from HCP. For one of the men, he described being optimistic about his overall health:

“but I’ve never been to the doctors for checkups and that, so it’s one of those where you just hope internally you’re OK because you’re exercising” (First Generation, Participant 1)

“personally I don’t go to the doctor often if I get a cold or flu I live with it and sort it out myself, I think it will pass and sometimes when it doesn’t then you do go to the doctor...” (First Generation, Participant 9)

Some of the participants spoke about other conditions which they were suffering from, such as high cholesterol and hypertension, which were considered to be less important to health in comparison to ‘serious illnesses’ such as T2D:

“I mean my diet has been like that and I haven’t had any serious illness in myself although I have been on blood pressure medication for the last ten years or so but it is still controlled but I still take the medicine and also cholesterol that’s the only medication I have and I have had problems, both my knees. I have had knee replacements. I have suffered for the last 10 or 12 years with that and still have you know problems with my joints and things like that but my knees are OK now they are perfectly fine...” (First Generation, Participant 3)

“I mean I'm taking cholesterol tablets, and that's advised by my GP. He sent me for all the tests and said everything was fine but the cholesterol was not dangerous but I was almost there” (First Generation, Participant 5)

The findings also revealed that the men's perceptions of health changed over time, with health becoming of greater importance with age. One participant explained his health only became a concern during the later stages of his life. For him, youth was defined by enjoyment, which left little time to think about health and illness:

“Because I was young, and you don't think about those things when you are young. It's only when you get old and the older you get all you become acclimatised with your own mortality” (First Generation, Participant 9)

(S) *“So during that time, were there times when you worried about your health?”*

“No it never it never crossed my mind. It was about having fun and having a good time” (First Generation, Participant 9)

One participant spoke about the specific age at which health becomes important to them. Age and health are seen to be in a linear relationship, where ageing is associated with poorer health:

“I think yes it does from a certain age onwards. Like when you're 50, one should make an effort to have a good look at how one has been living and try to sort out things” (First Generation, Participant 5)

The following will explore how the second-generation participants spoke about their perceptions of health.

Second-generation participants

In contrast to first-generation participants, second-generation participants spoke in depth about their perceptions of individual health, which related to a number of topics: T2D and health and age and health, which will be explored here.

- Individual perception of health T2D and general health

Some of the participants appeared to have a fair understanding of T2D as an epidemiological condition:

“my perception of the illness is that it is a chronic condition and it’s rife within south Asians and those who are obese ... It’s associated with cardiovascular conditions”

(Second Generation, Participant 5)

“and I know it does skip a generation, so if I know somebody has got it I’d rather me having it as opposed to my children, and try to educate them when I do have children”

(Second Generation, Participant 12)

“OK so let’s change the subject slightly and about type 2 diabetes itself and obviously I mentioned earlier that it particularly effects a lot of the south Asian community is this something that you are aware of?”

“erm kind of but not really, maybe a little” (Second Generation, Participant 1)

When talking about T2D, some of the participants identified the importance of maintaining ‘good health’, and cited ‘self-control’ and discipline as important components which could limit the chances of developing T2D:

“It is something that plays on my mind. I do think about it all the time but you have to have limits and self-control and discipline” (Second Generation, Participant 3)

“it is controllable and manageable if people are willing to change their behaviour or able to change their behaviour that is possible but it’s like with anything if you don’t look after it you don’t manage it’s going to get worse and I know people struggle with taking control and taking responsibility because it’s not always in their own hands..people recognise that they need to take responsibility that’s the one of the biggest steps” (Second Generation, Participant 5)

However, not all of the participants acknowledged the risks associated with T2D. Two participants revealed that whilst they were aware of the condition, they admitted to having little concern for T2D as a potential illness:

“no not in terms of specific illnesses that I stress about or think about too much”
(Second Generation, Participant 13)

“it doesn’t worry be because I’m ok, I don’t get out of breath or anything like that so I’m ok...I think it’s better not to think too much or you get worried” (Second Generation, Participant 8)

In regards to their general health, the men carried out specific behavioural practices in an effort to ‘be healthy’. Importance was attached to the concept of being ‘health conscious’, which influenced certain behaviours such as alcohol intake and diet:

“I’m not in the best health at the moment ... so I’m trying to eat more salads and drink less alcohol and try a bit be more health conscious” (Second Generation, Participant 12)

“Health-wise I am quite cautious now but it’s only recently that I’ve started thinking about what I eat and when I actually eat” (Second Generation, Participant 9)

Similarly to first-generation participants, some of the second-generation participants did not seek medical advice from HCPs in times of illness. One participant self-diagnosed his recent physical pain, instead of seeking professional medical care. As a result, he identified his excessive consumption of alcohol as the cause of his pain:

“What things would make you think about your health?”

“Because I started getting pains and that and stuff like that it’s not good”

“What made you think that was alcohol?”

“I don’t know you know because alcohol plays a big part on your body and I thought majority of the time it was alcohol” (Second Generation, Participant 7)

- Age and health

Many of the participants spoke about the relationship between age and health. For these men, growing older and ageing was perceived to be synonymous with poor health:

“but I’ve realised when you’re younger you don’t realise the difference as much, but when you get older it takes a bit more of a toll on your body” (Second Generation, Participant 12)

“I’ve recently just joined a gym and you know that diet plays a big part of it, so I feel like I’m at that age when I should be doing more things (Second Generation, Participant 13)

The men described their youth as a time where health was not of primary concern. One participant associated this time with living a carefree life, without the burden of worry about health:

“If I’m being blunt it’s because we’re young ... I’m young I don’t worry about things like diabetes, I’m worried about other things, there’s other things I’ve got to worry about, it could be personal stuff really ... I’m not health-conscious person I’m not worried about cancer or diabetes or other kinds of diseases or infections and that kind of stuff ... it doesn’t worry me because I am a careful person and I look after myself to a degree” (Second Generation, Participant 9)

The men in this group also described how ageing and becoming older influenced how they considered their health. For example, one participant described how as he became older, he had greater access to education which increased his awareness of health and illness. Similarly, another participant described how he became more aware of the health implications of fast food as he become older and learnt more about the health risks associated with fast food:

“but as we got older the more and more my sisters and I got educated we knew we shouldn’t be going to places like that because they were unhealthy before my parents that was a way of showing that they were treating us” (Second Generation, Participant 5)

The men also perceived weight gain to be a result of ageing, which was considered to be detrimental to overall health:

“as you get older it easy to put on weight and you have to do more so you maintain your weight ... so it's not about physique but keeping fit as well so it just helps doesn't it if you're tired just to keep active” (Second Generation, Participant 13)

Summary

The first-generation participants did not talk in depth about their own health. In addition, they appeared to avoid seeking medical advice from HCPs. Whilst the men perceived T2D to be a threat to their health, other conditions such as hypertension were perceived as less of a threat in comparison. Discussions about age and health revealed that this group of men did not accept health risks until later life. This finding is particularly revealing as it demonstrates that health-risk management amongst this group might not be particularly effective. Similarly to the first generation, the second-generation participants did not seek the help of HCP in times of illness, and appeared to manage their health status alone.

These findings reveal that both groups of men share a similar reluctance in seeking health advice from HCP. In addition, it could be argued that the second-generation men have replicated this behaviour from their elders.

As well as this, the concept of age was inextricably linked to health for both groups. Nevertheless, a number of differences emerged in the findings which revealed that the second-generation participants spoke more about their individual health, especially in relation to food and diet, health and intoxicants, which will be explored next.

- Food and alcohol

Second-generation participants

During discussions about their health, the second generation participants spoke about their food and dietary practices. For many of these men, their diets were composed of a mix of both traditional Indian Punjabi food and western food. The men perceived the traditional Indian Punjabi diet as unhealthy, due to the use and consumption of 'risky' ingredients including sugar, fat, ghee and oil. In addition, these foodstuffs were also perceived to be a risk to health in western foods:

"I wouldn't eat it but then again there are certain foods in the morning I'll eat yoghurt and fruit and Weetabix and porridge it's not like eating Cheerios or lucky charms"

(Second Generation, Participant 5)

"It's English food now but I use my George Foreman grill and that gets the grease out of it because it sometimes ends up burnt, I do fish fingers and burgers in there and chicken it takes all the oil out of it"

(Second Generation, Participant 12)

Other foodstuffs were also classified as being potentially damaging to health, such as carbohydrate-based foods and junk foods, such as sweet and savoury snacks:

"I don't eat white bread at all. I avoid it at all costs, recently I went to the doctor's and they told me that my cholesterol was quite high so I have sort of cut down on junk food ... chocolate crisps etc like I used to have a packet of cheese and onion every day"

(Second Generation, Participant 13)

"so I have started to eat less bread as well like carbs because salt is bad for your stomach it's not good for you" (Second Generation, Participant 12)

“I don’t have chocolates as well because I know I will end up putting on weight and it’s not worth it really I don’t like chocolate that much” (Second Generation, Participant 6)

One participant highlighted the similarity across the first and second generations in regards to their consumption of these foods and described how both groups engage in similar food practices but at different places:

“different people of different generations go to different places ... so you might see the first generation go to the sweet centres but the younger second generation go to Pizza Hut, Burger King and crappy places” (Second Generation, Participant 5)

The men spoke about their perceptions of intoxicants, namely alcohol, with only one participant referring to the use of drugs. This section focuses on how participants spoke about the uses of intoxicants and the implications they pose to individual health. Most of the participants described their intake of alcohol as conservative. For some, drinking was restricted to social gatherings:

“if I’m out I have no problem in having a drink and having a red bell to limit myself because sometimes I enjoy doing that when I go out sometimes. I enjoy a drink to loosen up and unwind, I don’t always like the idea of not being in control of all my senses and if I am going to go out and drink I will only do it with people who I can trust...” (Second Generation, Participant 3)

“I won’t drink excessively and it’s not like I drink every day it’s when I go out with my mates and have a few then and weddings and parties and stuff” (Second Generation, Participant 9)

“I used to drink when I was younger but then I stopped, I don’t have any now to be honest with you” (Second Generation, Participant 11)

When asked if they thought about the health risks associated with drinking, almost all participants admitted to not thinking about the risks alcohol posed to their health:

“if I got mashed one weekend, nah I wouldn’t” (Second Generation, Participant 13)

“to be honest I don’t really think about it, but I should” (Second Generation, Participant 1)

When probed further, some admitted to being in denial about the detrimental effects alcohol has on health:

“I don’t, to be honest with you I don’t know why maybe it’s just denial, of facing reality that if you do drink quite a lot you will probably have problems when you are older. I don’t really pay much attention to it. I know I should but I don’t really, I’m optimistic that everything will be OK” (Second Generation, Participant 1)

Another participant described the ways in which the health effects of alcohol were only considered in relation to its short-term effects:

“I always never ever ever want to get to that point where you feel so rough you puke up ... So I’ve never intended to get to that point so it’s always shit I shouldn’t have done that I think shit I shouldn’t have drank that much ... I don’t think what effect that has had on to my body not really” (Second Generation, Participant 13)

However, this perspective was not shared by all of the men. One participant described his awareness of the associated risks of alcohol, which had led him to cut down his intake over time:

“now I understand the consequences and the stupid actions so I've cut down now I don't see the point in drinking” (Second Generation, Participant 12)

For another participant, the potential health risks of alcohol were identified and managed through ‘breaks’. Breaks were described by this participant as being time periods in which he would temporarily stop drinking. He identified the need for breaks when he considered his intake to be excessive and his health to be suffering as a result. However, despite recognising the health implications associated with alcohol, he admitted he would always resume his drinking due to boredom:

“That’s interesting because you when you think you had enough you’d stop and have a break, do you think it’s important for your body to have a break?”

“Yeah definitely”

“and did you think to yourself OK I won’t drink any more for a bit?”

“Yeah but then after a while I started again”

“Why?”

“Boredom you know nothing to do, nothing else to do might as well have a drink”
(Second Generation, Participant 7)

For other men, they perceived the habit of drinking excessively as a hazard, but not necessarily to health. For example, one participant explained how drinking in excess is a risk factor for unsightly weight gain:

“I don’t drink pints that much because I think that will increase the chance of me getting a beer belly or putting on serious weight so I never drink a lot of beer. I have a

pint of Guinness now and then and apart from that it's spirits" (Second Generation, Participant 13)

For some of the other men, they spoke about managing their intake of alcohol in order to play well in sporting activities such as football. For example, one participant explained how the short-term effects of drinking, namely hangovers, posed a threat to his ability to play football well. He went on to explain that he had chosen to reduce his alcohol intake primarily due to the fact that it posed a threat to his overall fitness, and therefore his football skills:

"Your body doesn't take it as well! And I didn't want to have hangovers so when I used to play football I used to drink heavily and then I had football and you're not moving as well and it stops you and I found it annoying..."(Second Generation, Participant 12)

"...So I cut down less and made sure my fitness was better because I wanted to do something that I enjoyed" (Second Generation, Participant 12)

During discussions about their drinking behaviours, the concepts of 'control' and 'limits' were described as important features to have when drinking alcohol. The limit was identified as a point in which drinking should stop once control was lost:

"but it's the same with men and women you should know your limit and not go past that limit" (Second Generation, Participant 13)

"to be honest I I've always been pretty good at knowing my limit and I stick to my limit because I don't like to black out and lose total control once I hit my limit. I take it easy, and that's because I've grown up in a family where nobody has really got that never to that level of excessiveness, we've always controlled ourselves" (Second Generation, Participant 9)

“and everyone gives you one a wedding but you should show self-control that you don't have to drink and if you do drink you can control yourself” (Second Generation, Participant 12)

Being in control was of particular importance when in the presence of others, such as family and friends. For example, one participant spoke about the importance of being in control at social gatherings such as weddings, where others might pass judgements about drunken behaviour:

“and I thought if I want to get married, somebody sees me at a wedding off my face..so it's an impression as well I want to have self-control to say no and be aware of what it does and be mature enough to say no” (Second Generation, Participant 12)

Summary

The second-generation participants were more open when discussing their perceptions of health and what health meant to them. The second-generation participants also spoke about their diet, and the implications of risk foods in their traditional and western diets. This group were also more open than the first generation in discussing their alcohol consumption. It could be argued that the second generation were more inclined to discuss their own health as opposed to the health of the community due to their detachment from the Indian Punjabi community. In contrast, the first-generation participants spoke in detail about the health of the collective Indian Punjabi community and their perceptions of risk, which will be explored next.

- Collective perceptions of health

First-generation participants

First-generation participants spoke more about their perceptions of the health of the collective Indian Punjabi community. The 'collective' is used here to describe other Indian Punjabi first-generation migrants living in the UK, who were perceived to be in poor health due to their health practices related to alcohol consumption and dietary habits. Discussions about the collective community were characterised by acknowledgment that the collective Indian Punjabi community are at increased risk of T2D. Participants described how chronic conditions such as T2D often become well developed as the community are complacent about health issues until complications become more apparent:

"I have seen a lot of my relatives who suddenly had heart problems and the doctor says only have boiled vegetables. You know? Why do they have to be 60 or 75 to realise that?" (First Generation, Participant 5)

"actually it's really surprising, people I think in general are complacent. The classic case is, 'oh I got this problem', 'oh go and see the doctor', 'oh I will go and see him tomorrow', it's the complacency, despite the case where until it hits you right in the face you don't go and take the action. I think this is one thing that needs to be looked into" (First Generation, Participant 4)

As previously mentioned, the first-generation participants identified two factors which they perceived as contributing to the poor health of the Indian Punjabi collective: a) excessive alcohol consumption and b) poor diet, which will be explored next.

- Excessive alcohol consumption

The first-generation participants spoke in depth about how other men in the Indian Punjabi community consume excessive amounts of alcohol. They identified that alcohol features heavily in the lives of other Indian Punjabi men, however the participants rarely spoke about their own alcohol consumption.

For men in the community, drinking alcohol in excess was described as the 'norm', which occurred typically during social occasions:

"I don't think there is any event without alcohol" (First Generation, Participant 6)

"I suppose we see it at our weddings, don't we? You know, have one more drink, and have one more drink! We seem to succumb to the party mood, I do as well, I do as well" (First Generation, Participant 1)

"In India we never used to drink, but here the drink is very common which is very bad" (First Generation, Participant 7)

Participants also spoke about how alcohol is consumed differently amongst the first and second generations. Some referred to the first generation as being more likely to consume alcohol excessively due to their inability to control their intake:

"alcohol is bad if it's taken out of proportion, if it's a source of pleasure and entertainment and it can be positive feeling but it's to understand when to realise that it's more of a bad thing... and children in this country, probably mature children, they know when to say no and people from India (sic first generation)..once they start drinking they find it hard to find the limit" (First Generation, Participant 7)

“Like I've said I've got a son he will only have a glass of wine and the younger generation are actually a lot better than us!. Because in comparison to us I've seen people drinking whiskey and gurgling it out because they paid the money and they want to make sure they get their value for money” (First Generation, Participant 5)

In contrast, one participant spoke about how the excessive drinking habits of the first generation are being replicated in the younger generations, which is influencing the reproduction of similar habits:

“but I might join the boys and have a drink, but that's all changed as well the way the men drink, the elders don't drink that much now, whereas before the younger boys would drink to excess and when they get going, I can't keep up with them!” (First Generation, Participant 9)

When asked to explain this further, he identified youth as a barrier to health, which allows the younger generation to participate in bad practices with alcohol:

“It's just the exuberance of youth because they can! I know if I drink half of what they did I would suffer for the next two days! It would take that long to recover, but they shrug it off the next day because they are young and they can” (First Generation, Participant 9)

- Food and diet

The first-generation participants also identified the dietary practices of the Indian Punjabi community as contributing to their poor health, as the traditional Indian diet was perceived as unhealthy. The men described the traditional Indian diet as being

characterised by the consumption of unhealthy food ingredients such as clarified butter (ghee), oil, fat and sugar.

The men considered these food ingredients as contributing to the prevalence of T2D within the Indian Punjabi community. One participant described how these food ingredients continue to be an inherent part of the Indian Punjabi culture, despite the awareness of the health implications surrounding these foods:

“I think we have the habits which eat a lot of fatty foods, butter and clarified butter. There still people who think that is good for you and they would rather buy sweets made of the ghee rather than those made with vegetable oil because the old Indian thinking is that butter's better, but it isn't. It's still going on and that's what's causing cholesterol issues” (First Generation, Participant 6)

These ingredients were also described as possessing the characteristics of illness such as T2D:

“They eat a lot a lot of food which could be the cause of heart problems and any of the diseases. And in India you always like sweet things and they are the worst thing such as rice puddings or Indian sweets. They are full of diabetes and sugar” (First Generation, Participant 7)

The men described traditional Indian foods as being deeply embedded within the community, which contributed to the risk of those in the community. For example, the men spoke about how Gurdwaras across the UK continue to use unhealthy food ingredients in their langar (the offering of free food to others):

“When you go to Gurdwara there’s a lot of sweets ... we take sweets to people’s house and they bring sweets and although it’s bad ..., it’s a culture and I think people should give priority to their health” (First Generation, Participant 2)

“We went to a wedding recently and they were serving sweets in the Gurdwara, doesn’t matter that it was first thing in the morning, it’s not good for people” (First Generation, Participant 11)

Participants also discussed the origins of these traditional foods, which had specific purposes in India. One participant described how aspects of the Indian diet were considered as facilitating to health when they were consumed within India. For example, foods containing fat were considered to create energy and facilitate strenuous work life in India. He goes on to explain how these foods became unhealthy once they were consumed outside of India, and are now the cause of the health problems and prevalence of T2D in the UK:

“so all the cooking habits came from India, I think they might have slightly pronounced they started doing things in their own way, to make it more tasty according to the tastes they had developed, but not realising that the food being consumed it might have worked well in India but because of the weather in this country, it wasn’t very helpful, so I mean clarified butter, it’s a classic case in India, all right it’s OK in India but over here it causes a hell of a lot of problems. I think over the years with that sort of attitude, this and that I think people started having problems in later life, similarly in the not realising sugar could cause problems, carried on taking it and not even know there’s somebody might be suffering from diabetes or whatever, and when it’s time to go and see the doctor, just to maintain or do whatever needs to be done the way you think it is right until you find there really is something terribly wrong and then you look

into it, and that sort of thing ... so all those food habits it's definitely were Indian habits, but they might have, they might have pronounced them in a better way but not realising the health problems that they will bring" (First Generation, Participant 4)

Another participant described how certain foods high in sugar such as pershad (religious sweet) and kraa (semolina based desserts) were consumed during the Indian winter to promote energy. He goes on to discuss the implications in the change of environment during migration and the continuation of the consumption of these foods:

"in India, in the winter people tend to eat more, like pershad and kraa they make that in winter and they still have the same habits in this country and when the winter comes they make it and eat it but there's no need for this, but habits are changing but only very gradually" (First Generation, Participant 2)

The first generation men also spoke about the community's poor dietary habits as originating in India, which became difficult to change once migrants settled in the UK. The men spoke about the offering of foods at social events, and the inherent pressure which exists to consume them. One participant talked about his inability to understand why the collective community still consume unhealthy foods such as fried snacks (samosas), despite the health implications associated with fried foods being known:

"When you're born you develop some certain habits over years and years you can't difficult to changes some people crave for certain things, this could be because of health reasons. Not every Punjabi likes sweets, some don't, but whenever you go in

India any function its sweets are the give and take and people take them and give them you go to weddings and sweets everywhere, fatty food everywhere, fried food everywhere ... we still have the same habits here ... if somebody comes over we give them samosas (fried snacks), if we go they give us samosas, everybody knows they are bad for you but ... they say 'kala' (eat one) and then you have one but it's contributing to the bad health" (First Generation, Participant 2)

However, some of the men acknowledged that these practices are slowly changing as awareness of health risks increases. Despite the acknowledgement that food habits are changing within the community, another participant poignantly referred to these changes as coming little too late:

"we like butter, ghee which is purified butter in a way, I mean we have always used that for cooking and most of our people are changing we know not to use that much, but with the first generation it was defiantly was that" (First Generation, Participant 3)

"So instead of using ghee we use olive oil but these things came too late" (First Generation, Participant 7)

The following section will describe how the second-generation participants spoke about the health of the collective community.

Not many of the second-generation participants spoke about the health of the collective Indian Punjabi community. Some identified the community as being at risk of conditions such as T2D, and a few explained why they thought this to be. When talking about the collective community, they were speaking about members of the first generation in the UK. In addition, the first generation were described as a group who have relatively low awareness of the risks of conditions such as T2D.

“erm a lot of them, a lot, I would say 80%, just from what I have seen, I think they are very much stubborn in their ways and they really do not understand health at all until it’s too late and until they have got a few years to live but it’s almost pointless making those changes then because it’s too late” (Second Generation, Participant 2)

Another participant explained how the first generation are at an increased risk of T2D due to the fact that they tend to accept their illnesses, and look for ways to keep it under control, and oppose seeking preventative measures:

“they don’t really adapt, they don’t look for what they can do to prevent it and what can keep it under control, maybe I’m wrong, I do think people go out of their way to drastically cut it out but I think they look for the controlling measures as opposed to prevention” (Second Generation, Participant 3)

Another participant explained the importance of raising awareness of T2D amongst the first generation, and informing them about the importance of diet management to control the onset of T2D:

“cos it’s quite high in Asian men, in theory they should realise that as a result they could be prone to it as well and to find out more information themselves in an ideal world ... and counter attack it and make sure that they are on the right diet, exercise and having that advice ... early rather than later” (Second Generation, Participant 2)

This group also spoke about the dietary practices of first generation men in the community. During these discussions, there was an overall agreement that the dietary habits of the first generation are nutritionally poor, and contain unhealthy food ingredients such as cooking oil and ghee oil, salt and butter, which were perceived to be detrimental to health:

“they would eat chapattis every day, and normally food that’s cooked in cooking oil, but I think things have changed slightly but those things are still prominent now”

(Second Generation, Participant 2)

“whereas in Indian food, especially homemade Indian food it’s still very traditional, so for instance the use of a lot of butter and a lot of salt” (Second Generation, Participant 1)

Despite the continued consumption of these ingredients in the community, one participant explained why these foods are still regularly eaten due to their ability to produce an authentic taste:

“I do think Indian food is unhealthy to a degree, because after seeing how it is prepared, Indian food is very rich and oil heavy, and sometimes even if you try and compensate on your quantities you don’t get the full authenticity of it and of what it was meant to be, and especially if you go back home to India, you have no choice”

(Second Generation, Participant 3)

Summary

The first-generation participants seemed more willing to talk about the health status of others in the community. Contrastingly, second-generation participants were reserved when talking about the health of the collective community. They perceived the first generation as a group with little awareness of T2D, who are characterised by denial. Nevertheless, T2D was recognised as a significant health risk to the community by both groups. Whilst perceptions of risk and health varied across both generations, food and alcohol were identified as the main contributors to the

development of T2D and poor health within the Indian Punjabi community. This is an important finding if we are to identify and understand the specific barriers to health which exist within this population.

The following section describes how the men spoke about the consumption of food and alcohol in various social settings.

5.1.2 The socio-cultural context of food and alcohol

As previously mentioned, the men perceived food and alcohol as the main contributors to the prevalence of T2D in the community. During the discussions about food and alcohol, it became apparent that they play a significant role during social gatherings within the Indian Punjabi community. Cultural practices related to food and alcohol were also described as being deeply embedded within the Indian Punjabi social sphere as they are linked to identity and representations of the self. This chapter will begin by exploring how the first generations spoke about the social significance of food (see Table 13):

Table 13. Data summary: Socio-cultural context of food and alcohol

	First generation participants	Second generation participants
Socio-cultural context of food and alcohol	<ul style="list-style-type: none">• Food and social identity• Alcohol consumption	<ul style="list-style-type: none">• Alcohol consumption

- Food and social identity

First-generation participants

Participants spoke about the traditional Indian Punjabi food as being inherently unhealthy, with specific ingredients being detrimental to health. Despite this, consumption of these foods continues within the community due to the cultural meanings attached to traditional food, especially in relation to the social significance of food and the role it plays in influencing status and social identity. One reoccurring theme which emerged from these discussions was how food correlates with social standing and success. For example, participants described the ways in which food is offered in abundance to guests at social events, which is a representation of the affluence of the host:

“It is yes a bit of it is to show how affluent they are, because in my experience as well the food and alcohol its joint and part and parcel of these occasions....

...because everybody wants to, they want their wedding to be the best and the most memorable so they try and do as much as they can to what their means are and then they go over the top” (First Generation, Participant 9)

As a result, food is often wasted. One participant described his disdain in the ways in which food is used as a way of ‘showing off’:

“but the amount of money that is wasted to me seems criminal, I'd rather see it go to a better use. If you've got it that's fine but stay within your means, but unfortunately people are going outside of their means to provide that one day and it's not being appreciated. And I think the way forward is to go the opposite way rather than being over the top, be minimalist. You know weddings are celebrations it doesn't have to

mean you have to provide alcohol of that nature, celebration is a state of mind, stop alcohol to a certain state, yes it is regarding as a celebratory thing, food yes eat good food but does it need to be wasted? No it doesn't, stop. One needs to be respectful of how it gets there in the first place, and Asian weddings in particular, 60 to 70% of it will go to waste" (First Generation, Participant 8)

The presentation of food at social events is directly related to the importance of being seen as a good host. A cultural pressure was described as existing within the community which places hosting as an integral cultural necessity. As a result, one of the requirements of a successful host lies in providing plenty of traditional food for guests:

"it's just habits, it's not pressure, it's a social pressure you can say ... there's a lot of display ... it is true that we Indian hosts and Punjabi hosts are very good hosts and we want to treat our guests and pamper our guests and make them, him or her at home and at ease and give them whatever they want make them feel comfortable with food everything ... and drink, offer them a drink even if they don't want one they still get one ... it's part of hospitality (First Generation, Participant 2)

"yes that's true, I really don't know just what we are trying to prove, well we are generous by heart anyway. I mean we think a guest has to be pampered and all that especially at these..." (First Generation, Participant 3)

It becomes apparent that food is used as a way to represent the self, and therefore a form of social capital. One participant described how this has come to be, and identified the cultural origins in India and how social relationships have formed, to explain how guest and host roles have come to be established. The importance of maintaining status is seen to have emerged from important social encounters, such

as marriage proposals, where representing the self and family are seen to be crucial in projecting a good self-image:

“Yes I think it started off in India, especially with the few generations such as my granddad, like if the in-laws of the females were here and there was no drink they would say take the daughter back! So you had to go over the top to keep them happy!” (First Generation, Participant 9)

- Alcohol consumption

First-generation participants

The first-generation participants spoke about the consumption of alcohol and the cultural attitudes Indian men have about alcohol. Heavy drinking is largely practised amongst men during social gatherings, such as family events and weddings. In these settings, alcohol was described as a way of displaying personal affluence to others:

“I think it's the way the Indian community are, and the way ... I can't think of the right word ... Of what it is ... (long pause) it's hard to put into words, it's ... It's all about honour, especially in the old days when guests came and in-laws, you had to provide a good meal and drinks especially for in-laws of the female, the daughters-in-law, because that was an honour thing...

...it's always 'have another one have another', and you say no but you still have another one. I suppose it's to do more with prestige” (First Generation, Participant 9)

The participants also spoke about the social pressures men face to consume alcohol and the repercussions which occur when departing from group social norms. Within social groups, abstaining is perceived as a socially deviant act and discourteous, as drinking with others is a form of respect; it shows you are celebrating with the host. One participant spoke about the social repercussions he faced when choosing to abstain from alcohol during a friend's celebration:

"Yeah I gave up drinking two or three times. And the only reason I start again was due to peer pressure. I mean I went to this family event, and we have a relative, his son was born very premature, but he survived and he had a party for him. Then I went to that party, and he said no you've got to have a drink when I said no, but then the love for the person goes and the happiness of the day.. I just slipped again" (First Generation, Participant 5)

Similarly, abstaining from alcohol in a group also draws attention from others. For example, one participant's health was interrogated by friends when he chose not to drink. In this case, breaking away from the social norm was perceived by others to be a result of a health issue or illness:

"When I gave up and I sat with them and when I said I was not drinking, they would say all what is wrong is it your health? Have you got diabetes? Have you got heart problems?" (First Generation, Participant 5)

The same participant also spoke about how men are more likely to drink around other men. This was due to the way men's consumption of alcohol is often monitored by the women of the family (wives and daughters):

“Because they want to drink! Because they are restricted if they're sitting with the family, that their daughter might say; ‘you’ve had enough, Dad’. I remember at your brother's wedding, and all the men sat there with were families, and then suddenly one moved and then the wives moved as well but they know it's going to happen”
(First Generation, Participant 5)

Second-generation participants also spoke about widespread abuse of alcohol in the Indian community, and its role at social gatherings, where excessive drinking is encouraged:

“so it's hand-in-hand in terms of celebration and alcohol?”

“Yes absolutely” (Second Generation, Participant 9)

“ yeah for some it is a problem....like at parties some men might down some drinks together but then is that having a problem or a good time that’s up to them really”
(Second Generation, Participant 11)

“do you think that for men in the Indian community alcohol is more of a problem?”

“Oh yeah some Indian men take it too far” (Second Generation, Participant 8)

“It’s just about drinking at weddings and parties” (First Generation, Participant 7)

Participants cited a number of reasons as to why alcohol is consumed in this way, but one of the main reasons was due to the ways in which it aids socialisation with others:

“So it's a very touchy subject because everybody believes in drinking and socialising ... I’m the type of person who can do the same thing I can do normally as if I was

drunk, so I don't need that confidence, so if I'm drunk and you see me or happy that exactly how I am when sober, I don't need it" (Second Generation, Participant 3)

In another example, one participant described a time when unknown relatives visited his home and alcohol was served as a way of getting to know them. He spoke of the ease once the guests began drinking, as everybody became relaxed and more sociable. In this instance, alcohol was actively used as a tool to facilitate socialisation:

"yes because when you look at it when blokes are together, like for example my brother, when he was going to get married his in-laws came over and everybody is quieter nobody knows what to say, as soon as the cans start popping and they all start talking and chilling and it breaks down barriers for them" (Second Generation, Participant 13)

Drinking alcohol was also a way to enhance mood and atmosphere, as one participant described the ways in which alcohol plays a role in enjoyment and having fun at weddings:

"To be honest I went to a wedding recently, just yesterday and it was a Radaswami (religious caste) wedding so there was no meat and there was no drink but then you could just tell that the atmosphere wasn't.. it's harsh to say it wasn't the same, but it wasn't the same, I like to have a drink.. if I go to somebody's wedding I will have a drink and it loosens the guys up and you have more of a laugh when you have a couple of drinks" (Second Generation, Participant 9)

Similarly to the first generation, participants also spoke of the social pressures they face when drinking alcohol around others:

do you think there is pressure on some men to drink?

“Oh yeah definitely, yeah, in a social groups it’s still quite a big thing being about to drink in front of your family and friends, it’s still quite ... it’s still there I think so yeah there are pressures definitely” (Second Generation, Participant 2)

“Yeah peer pressure plays a part even if you didn’t want to drink” (Second Generation, Participant 7)

“ erm yeh there is pressure to drink but it’s done in a banter way, like there have been times when I have been drinking with my cousins and people have said I’m not drinking and people will take the mick in a jokey way but you know it’s not like ‘oh my god I’m not going to talk to you if you don’t have a drink’, like you know it will be done in a banter way, and people will take the mick out of them a little bit and then that’s it really, but then deep down after a while people say oh that’s really good you’re not drinking in a way so it’s done in a jokey way it’s not really serious thing” (Second Generation, Participant 1)

“I think people drink due to peer pressure and it's the thing to do when you get older and you're old enough you can have a drink” (Second Generation, Participant 12)

The pressure to consume alcohol was also linked to the Sikh-Jat identity. One participant described how he felt pressured into drinking due to how others had constructed his identity and caste expectations:

“but no it's one of those things it's part of Asian culture...I remember my 18th birthday we had akaan part (religious practice) I wanted to go watch Lord of the Rings and my uncle said to me ‘remember you’re a Jat and Jats drink!’ And I was like OK so the pressure is on ... In the end I went to watch the film.. I do what I want to do” (Second Generation, Participant 13)

For some, drinking is considered to be an important part of the Sikh-Jat cultural identity. This demonstrates a link between identity alcohol consumption, of which a Sikh-Jat is seen to be someone who can and is expected to drink in excess. Nevertheless, it is important to highlight that the social norms within the Indian Punjabi culture dictate drinking as a gendered activity. One participant explained how women are traditionally expected to abstain from drinking at weddings. Nevertheless, he also acknowledged that times are changing and it is becomingly increasingly acceptable for women to drink, but not to lose complete control:

“yeah the women can't drink, but that is changing but you don't ever want to see the women being sick, but it is changing...a couple of weddings I've been to where the men drive home and the women get mashed on the wine” (Second Generation, Participant 13)

These restrictions are not only seen to be placed on women at weddings, but also amongst the men and how much they can drink and where. One participant described the ways in which it is deemed unacceptable to consume vast amounts of alcohol in the presence of family members:

“and I think back on influences sometimes you don't have lots of alcohol with you when women are sitting on the table but when you're with your family it's not respectful” (Second Generation, Participant 5)

Summary

This chapter has explored some of the micro socio-cultural factors which influence the health of Indian Punjabi men. Practices and behaviours related to food and

alcohol within social settings were identified as contributing to the poor health within the Indian Punjabi community. The findings revealed the extent to which food and alcohol possess a social function at gatherings and family events. This was largely associated with the cultural meanings and values these practices hold within the Indian Punjabi community. The findings also reveal the implications these practices have on personal identity, which demonstrates how deeply embedded they are within the cultural life world of the community. The next section describes how the men spoke about certain health risks and how they come to be in certain settings.

5.1.3 Health risks and place

It is widely recognised that people's perceptions about health do not occur within a value-free context, and are shaped and influenced by society, time and place (Bury,2001). This section of the findings focuses on how the men identified particular times in their life when place influences health. This chapter begins by focusing on the experiences of the first-generation participants who spoke about the collective experience of migration and the effect of living in the UK on their health. They highlighted the migration process and the aftermath of migration as contributing to health discrepancies within the community. Participants spoke about this way of life, and the impact it had on the health of those who migrated to the UK from the 1960s onwards. This chapter also explores the second-generation participants' discussions about their time at university and how it became a place where they often engaged in irresponsible health choices.

Two main themes emerged from the first-generation participants' discussions: life in pre-migration India and life in the UK post-migration (see Table 14):

Table 14. Data summary: Health and place

	First generation participants	Second generation participants
Health and place	<ul style="list-style-type: none"> • Pre-migration India and health • Life post-migration and health 	<ul style="list-style-type: none"> • University life and health

- Pre-migration India and health

First-generation participants

The Indian Punjabi community were perceived by the first generation to be at risk of health conditions due to lifestyle factors related to poor dietary habits and excessive alcohol consumption. These trends were described as originating from a specific context and place: 1940s/1950s pre-migration life in India. Life in India pre-migration was characterised by strenuous physical work and poor dietary habits. During this time in India, specific lifestyle behaviours were common, such as the consumption of foods high in fat and sugar. This was so men could carry out physical work on the farms in the Punjab. In this context, these foods had specific properties such as providing energy for those who participated in hard laboured work. After mass migration to the UK, these dietary trends continued in the absence of physical work, which resulted in a number of health complications for south Asians living the UK. Two participants described how these health behaviours have come to be and how the properties of food changed in different places:

“in India in my time it was special dish used to be sugar cane and butter mixed, that used to be a special dish and those who did well or if they were from a good family they would have it with the food. Those things in those days were rare and because the climate and physical struggle of life was also contributing towards the digestion or making a good use of it, and physical work needed a lot of energy and this was energy provided by food ... now ... that kind of physical hard work is almost disappearing but eating habits are still the same for some of our people ... as a result of that why they are obese have diabetes, heart problems” (First Generation, Participant 2)

“in those days they used to do a lot of exercises and it was part of their sport and work it was hard work sugar working on a farm they didn't have machinery, that they were strong people and they needed to eat well, but over time a lot of machinery has been introduced into farming and all sorts of life and people are working as hard but the diet is the same and they still feel they have to eat well” (First Generation, Participant 10)

Excessive alcohol consumption amongst men was described as the norm which was embedded within the cultural and social practices of life. In this context, alcohol was consumed for a specific purpose: as a source of relaxation from intense physical labour and farming. Before the introduction of machinery in the Punjab, participants described how men worked under strenuous conditions, and drinking became a legitimate respite from a hard working life. As machinery became introduced to farming, intensive labour reduced, but the patterns of alcohol consumption remained the same. It is under these complex conditions that the excessive consumption of alcohol is seen to have evolved from:

“Most of the farmers in the village, you got a few who used to distil their own alcohol and make their own, or they would buy from the one who was making it, that sort of thing. But the thing is they worked extremely hard. And farmers don't work like that anymore so they would work all day and then have a bit of whiskey in the evening and then go to work again but things have changed because they do less work but they still drink more” (First Generation, Participant 6)

“Of course it's different now because the farming methods have changed and they are more progressed now than before, but I mean before the mechanisation of farms and all that they really struggled and then only at festival times they had a bit of money and all that and of course celebrated that, and then because it only happened once they over did it anyway, and then its somehow inherent, they make them feel great that's how it started I suppose” (First Generation, Participant 3)

The health problems Indian Punjabis face today have been contextualised as originating in India. Participants spoke collectively about the first generation, who were seen to have replicated the lifestyle adopted in India to the UK. Within the context of India, health behaviours were not seen to be detrimental to health, due to the characteristics of the environment. It is only when the environment changed, that the consequences of these behaviours changed to become hazardous to health. Here, place plays a significant role in the development of specific lifestyle practices, which have transformed to become damaging to health in a new place. The next section explores how the participants spoke about life in the UK post-migration and the development of health risks in a new place.

- Life post-migration and health

When they were asked to talk about life in the UK post-migration (1950s onwards), almost all the first-generation men described it as a time defined by hardship and struggle. As a result, health became affected due to a number of lifestyle factors, including their poor living conditions. The men described the hardships of living in cramped accommodation with other migrant men, which had consequences for the ways in which they were able to cook food for themselves. Two participants described how men would typically come together to cook meals under these circumstances. In addition, limited income and access to amenities inhibited the opportunities for consuming a healthy diet:

“But when you're on your own you cut corners. I remember the friends of mine who came they used to cook a big pot of chicken once a week” (First Generation, Participant 6)

“but some of these people who came here in those days they used to set up a combined kitchen say ten of them got together, OK so one of them to make the meal one day and make the chapattis you know the next day somebody else will do it and all that and they were actually quite good but they were just sort of stuck to the same basic I mean lentils for instance you know because they wanted to save money” (First Generation, Participant 3)

“and secondly because you didn't have a kitchen to yourself you shared it with other people all sorts of people so the most we could do was probably fry an egg or heat the beans up or toast and these are the things we did, like I mentioned earlier at weekends we did cook you know, chicken or something like that ... boiled some rice” (First Generation, Participant 3)

In addition, traditional Indian food was described as a source of comfort during these trying times:

“but chicken or lamb or something like that that was their enjoyment time...we used to go to Birmingham city centre, and do our shopping there and bring it back, and cook it ourselves and Saturday night was the enjoyment time” (First Generation, Participant 4)

One participant described how traditional Indian cooking styles were replicated in the UK as western foods failed to meet the requirements of those who migrated:

“do you think those food habits and the cooking styles they have been learnt from India and been brought here?”

“yes definitely because for the older generation ... particularly people who worked and did nothing else. English food won’t work ... you mention fish and chips but they go mad like your mad or something” (First Generation, Participant 4)

Poor diet and an unhealthy lifestyle were also facilitated by the absence of Indian women in the home. Traditionally, men migrated to the UK first, bringing their spouses and wives later. Living without a spouse or female family member had repercussions on how some men were able to look after themselves.

In India, women were responsible for household duties such as cooking and cleaning and the health of some migrant men suffered due to their dependency on their partners or female family members:

“we were not used to cooking at all you know, never had an opportunity, the mothers did it or the sisters did it, things like that” (First Generation, Participant 3)

As a result, the men's diets suffered. One participant described how his inability to cook and prepare food influenced his diet, which mainly comprised of simple ingredients:

"but cooking was a problem we had never cooked in our life so we virtually survived on fish and chips in those days, beans, cheese, ham and things like that and at the weekend, we cooked, we had curry and all that, we had a good meal at the weekend but during the week that was the problem" (First Generation, Participant 3)

Nevertheless, not all participants lacked cooking skills, some of the men enjoyed cooking for themselves and having independence from their wives:

"I mean I used to be the youngest person in the family I used to cook everything, I cooked everything I can still cook if there is a need for it and we used to cook like all the ladies did in India" (First Generation, Participant 4)

"I learnt a lot from watching my father, so I can say I have picked up a few cooking skills along the way" (First Generation, Participant 11)

Alongside food, alcohol had a dominant role in the lives of these men. Participants described migration and adjusting to life in the UK as the catalyst which formed the drinking culture amongst migrant men. In this context, consuming alcohol was a legitimate way to relax:

"But here when we came, it was the pressure of work, you felt tired, plus with fatigue and cold, and once you adopted a certain idea it was difficult to get rid of it unless you were very strong-minded person. And those people they came to this environment when they were already drinking in India and these habits developed.....It was the

pressure; it was so different we were not used to it so in order to avoid all of that the relaxation was coming through drink” (First Generation, Participant 7)

Drinking alcohol was also a way of socialising with other men, and the pub became a place where migrant men came together and socialised with others who were in similar circumstances to their own:

“When I came, my father-in-law or my uncle they would have just come over and there was nothing for them so they drank. And if they were in the pub, that was after a day's work. It was unlike you sat down with the family or with the children. The men finished in the pubs” (First Generation, Participant 5)

“I mean we could mix very well with the host community because the English wasn't a barrier as such, but most of the other communities - the other Asians - really had this English problem. I mean they had absolutely no contact outside work, and even then it was only the pubs they went to and then they went to certain pubs only where they were frequent so that's why I mean that's why it took them so long to learn English and get used to it because they lived together, amongst themselves and they worked together” (First Generation, Participant 3)

“going to the pubs was the greatest enjoyment so they did not hesitate to consume that much beer or alcohol or whatever because whenever they were there they free that was the greatest thing they could have and enjoy themselves and laugh between themselves, say whatever you want to say”(First Generation, Participant 4)

Excessive drinking was also reinforced by increased choice and availability of alcohol in the UK:

“but in this country it is available everywhere and it’s easily accessible and it’s affordable, in India but they couldn’t afford it because it wasn’t accessible all the time”
(First Generation, Participant 2)

“Because, one it was freely available, and two they had a lot of varieties, then the spirits. Whereas they only knew the home-brewed beers in India, but over here my god they see whiskey and they hold the whiskey and they didn’t know what whiskey is, and all of a sudden Bacardi appears on the scene, oh my god, so many things, brandy my god, it’s very cold have some brandy, so because of the availability of the variety of the drinks that were available” (First Generation, Participant 4)

In addition, increased accumulation of wealth and financial stability also contributed to how first-generation men consumed alcohol. Participants referred to how the Indian community succeeded in business and employment, which resulted in them enjoying increased relative wealth. This wealth allowed the men to indulge in alcohol on specific occasions, primarily social events, where alcohol would be available in abundance:

“I think I can put a finger to why it’s become such an issue, because those who got into the business they had the money to spend. And they threw parties where alcohol was available in the next party had something bigger...now the weddings you can see how it is but, now it’s massive and so expensive and how an ordinary person can afford it I don’t know although some of our businessmen are doing very well. So you’ve got to throw a party better than the one before” (First Generation, Participant 6)

- University life and health

Second-generation participants

Place also influenced how the second generation took responsibility for their health, as participants described university as a place where poor health decisions became commonplace. The majority of the men identified their time at university as being characterised by poor health behaviours, specifically related to excessive alcohol consumption:

“I don’t think ... I don’t drink nowhere near enough as I used to at university, that’s one positive thing, which has come out of everything, but I do look back and think ‘oh my god I used to drink a lot’ but I don’t think like oh I regret it. I may do who knows but at the moment I don’t really regret it” (Second Generation, Participant 1)

“I didn’t really look after myself when I was living on campus and not only that but I fell off the rails as well... I wasn’t getting drunk all the time but on the odd night out I would take it too far and have too much, more than necessary really, which is silly looking back because there was no point because it’s not as if you remember it the next day anyway so it’s a waste in the long run...” (Second Generation, Participant 6)

“I do think it’s changed I don’t know I just drank more and more but it is social thing” (Second Generation, Participant 13)

One participant described how drinking alcohol occurred on any occasion during his time at university:

“In what ways would you drink at university?”

“Well any occasion” (Second Generation, Participant 7)

The consumption of excessive amounts of alcohol at university was described as common practice amongst other south Asian students. Two participants described how drinking was a common feature of their socialising, and south Asian students in particular would often exceed their limits:

“You see those people going out, it’s not stereotyping, it’s just Asians, but a lot of people go out and drink when they go to university but with Asians you will notice that they will continue to drink the three years after you’ve done the first six months up until Christmas. Others might settle down, but no with Asians they carry on... my mate he went to a few different universities in three different years because he failed each year three times because he was going out and getting drunk every time”

(Second Generation, Participant 5)

“but drinking and stuff and going out is something which is the norm for Indian men and even when they go to university it’s not seem as anything different” (Second Generation, Participant 1)

When asked to expand on why people drank heavily at university, one participant explained how socialising with others and keeping ‘in trend’ were the two main influencing factors:

“Yes to get to know people because everybody was doing it” (Second Generation, Participant 7)

In addition, participants explained how many students felt free to consume excessive amounts of alcohol at university due to the lack of surveillance from others. It appears that university became a place where young men could indulge in alcohol away from the watchful eye of family:

“do you think it happens a lot when no one is watching?”

“Yeah it does, because then nobody will know” (Second Generation, Participant 7)

The consumption of alcohol during this time was considered as an integral part of the experience of learning. One participant stated the ineffectiveness of warning students of the health risks of excessive drinking. Instead, he argued that individuals must become wary of the responsibilities of alcohol for themselves. Here, importance is placed on experiencing the effects of alcohol for the self:

“I think it is because of something that you haven't done before, and it's experience, and you don't know that something until you've experienced it for yourself, you can somebody it's this and that but unless you've done it yourself” (Second Generation, Participant 12)

For some, drinking heavily had negative consequences for good health behaviours. For one participant, his introduction to alcohol during his time at college was seen to be linked with the diminishment of his overall health:

“it's about keeping active but from six form it took a dive and that's when you start drinking a bit and you discover alcohol and university comes along and that's where my sporting activity went down and I didn't do any kind of sports throughout the whole of university life, even then I would consider myself is quite healthy I was putting on fat but it was just recently...now that I've started to realise that put on a bit of weight so I need to start working out and take care of myself (Second Generation, Participant 9)

For others, university was identified as an unhealthy time, where health was not of primary concern. Two participants talked about how this time was defined by ‘having

fun', and health was not considered:

"could we talk a little bit about your background in terms of your times at university, how do you think about your health during that time?"

"yeah that was quite an unhealthy period of my life I would have to say, it was a lot of eating bad food, drinking a lot, I didn't really think about eating healthy to be honest with you it was quite a crazy four years ... I don't know why it wasn't something that I thought was a pressing matter, I just cared more about doing what was fun, so it was more about having a good time, I look back and I think that was a good time" (Second Generation, Participant 1)

"It's not a main concern for people, it's just about having fun and doing well at university like trying to pass and that's it really" (Second Generation, Participant 6)

Summary

These findings have explored the men's own experiences and perceptions of place and the effects it has had on health. The first generation refer back to pre-existing socio-cultural structures which were in place in India, and how they have influenced patterns of lifestyle behaviours and health in the UK.

The importance of place and shifting places becomes relevant in shaping how these men have come to understand the origins of health risk within the Indian Punjabi community today. Health risks were perceived to be deeply embedded within the diasporic narrative of those who journeyed from India, and later reinforced by the later migratory experiences in the UK. These explanations draw heavily on the socio-cultural forces at work which have shaped how health risks have come to be

developed in two places. This reinforces the finding that place plays a significant role in understanding how health risks have come to be and are reinforced within the Indian Punjabi community.

Similarly, place also played a role in how the second generation experienced health risks during their time at university. It becomes apparent that the second generation have replicated the drinking practices of their elders, but in a different place and time. The following section will describe how the men spoke about risk and the factors that they perceived as influencing the risk of T2D in the self and the community.

5.1.4 Risk Perception (i): Lay theories of disease causation and poor health

As previously mentioned, there was an overall agreement amongst both groups that the first generation are at increased risk of T2D. This chapter examines some of the ideas participants drew upon to explain the prevalence of poor health and health disparities within this group. Participants identified a number of concepts as contributing to the overall deterioration of health amongst the first generation, which related to their features as a group and external factors. Features of the first generation alluded to characteristics of the group that were perceived to be barriers to good health practices and were associated with identity, personal values and psychological well-being. External factors pertained to extraneous influences to do with the environment, education and social support. This chapter will expand on these concepts and how they unfolded in the men's discussions about the health of the first generation (see Table 15):

Table 15. Data summary: Risk perception (i)

	First generation	Second generation
Risk Perception	<ul style="list-style-type: none"> • Characteristics of the first-generation <ul style="list-style-type: none"> ○ Being masculine and independent ○ Drinking and maintaining masculinity ○ Attitudes towards, health, exercise and food ○ Psychological well-being and health • External factors <ul style="list-style-type: none"> ○ Social peer pressure <ul style="list-style-type: none"> ○ Environment and health ○ Lack of health education 	<ul style="list-style-type: none"> • Characteristics of the first-generation <ul style="list-style-type: none"> ○ Risky attitudes and habits ○ Exercise and interest ○ Denial and health • External factors <ul style="list-style-type: none"> ○ Lack of health education

- Characteristics of the first generation; Indian Punjabi male identity and health

First-generation participants

One of the dominant themes which arose during discussions about the health of the first-generation collective was masculinity and the male identity. All of the participants spoke about the ways in which the male identity plays a significant role in the health and health behaviours of this group. The participants described the socially constructed gender characteristics which are typical amongst masculine Indian Punjabi men, which were similar to hegemonic constructions of masculinity. For example, some of the common features of hegemonic masculinity are linked to the maintenance of a heterosexual male identity, and risk-taking behaviours which are hazardous to health (Harrison et al., 1992; Sabo and Gordon, 1995; Doyal, 2001). Similarly, participants identified the Indian Punjabi male identity and 'maleness' as having negative implications for their health as a group, and was cited as being one

of the contributing factors to the poor health of the first generation. Previous research has provided evidence about the relationship between masculine identities and risk taking (Connell, 1995), but little research has looked into the relationship between Indian Punjabi male identity and health.

This section explores how this group described their collective male identity and the common characteristics of the Indian Punjabi male identity.

- Being masculine and independent

As previously mentioned, the male Indian Punjabi identity described by the participants was similar to hegemonic constructions of masculinity; with strength and control being important features. This was demonstrated by how the men spoke about independence and taking control in relation to self health and care seeking behaviours:

“So even here, even I find people don't go to the doctors especially us Punjabis. We are quite macho people we don't bother going for help if it's a minor thing and even if people know there's something wrong with them, they try to put a brave face and not admit that there is something wrong, maybe we are not brave enough to deal with it or strong enough” (First Generation, Participant 10)

The Indian Punjabi male identity was also described as being dominated by pride, which was another barrier to help-seeking behaviours. The origins of this particular trait was explained by the same participant, who described how powerful men in the Indian Punjabi community are often those who appear to be in good health, and subsequently fail to visit health-care professionals:

“ they are regarded very highly in society people who don't go to the doctor, and don't bother about minor things and they think these people are powerful people and they're healthy, so when you start going to doctors for minor things you feel like your reputation is at stake, so these are the cultural things that people find going to the doctors trying to admit there is a problem, it is a weakness of the personality, that going to the doctor is not going to make you any weaker or stronger than what you were, that's my perception, and that's why some people feel healthy and that's why some people talk about it in a very proud way, I have been to the doctor in five years! There is a pride that there's somebody here, he was strong and I haven't been to the doctors of five years and this is a good sign of my health” (First Generation, Participant 10)

For Indian Punjabi men, maleness and maintaining one's male identity influences health. This was demonstrated by the first-generation men who, as a group, are independent and take control of how they look after themselves and their health. This is a particularly revealing finding which can reveal deeper meanings behind how the older generations seek health advice and services.

- Drinking and maintaining masculinity

Participants also spoke about the ways in which excessive alcohol consumption is linked to ideals about masculinity, and the importance of drinking for masculine identities. These practices typically occur within a particular social context. During these discussions, participants largely condemned the association between masculinity and alcohol, and stated it had no relevance or importance to themselves.

“I mean I drink to enjoy, I enjoy it I will tell you the truth I enjoy it, but yes I would say certain people from certain backgrounds do actually think that you’re more of a man if you can drink more for instance and all that, shout louder after you’ve had a drink but that is stupid in my view absolutely stupid” (First Generation, Participant 3)

“It’s almost judged by how much you can drink and eat it’s that sort of influence, if you don’t you’re sort of perceived as weak or you’re under the thumb that sort of attitude you have to be the alpha male, you have to always show you know, I’m the man in the house” (First Generation, Participant 1)

Displaying masculinity to others was considered to be most prominent in social settings, which would often give way to risky behaviours. One participant spoke of his experience witnessing men driving whilst under the influence of alcohol:

“It happens, and you see a lot of it at the weddings, they are knocking the beer or the spirits back and they still insist on driving even though they have probably got a partner who can drive so it’s like I’ve still got to be in control, I’m the man I can drink, even if I drink over the limit” (First Generation, Participant 1)

- Attitudes towards health, exercise and food

Indian Punjabi men were also described as a group who share a specific set of attitudes which contribute to their poor health, especially with regard to the choices they make about health, exercise and food. For example, participants spoke of the dismissive attitude Indian Punjabi men tend to have towards their health:

“But they are aware whether they do it or not, because it is well publicised the risk of getting diabetes to alcohol and smoking and other factors ... The majority of them do

understand but whether it's a lifestyle that they lead, the consequences it can have ... they are aware of it but they think it's not going to happen to them and somebody else" (First Generation, Participant 8)

Nevertheless, not all of the participants considered Indian Punjabi men's attitude to health to be dismissive. One participant described the ways in which the first generation are able to manage illness when prompted by health-care professionals:

"but it's only if the doctors have had the health check and the doctor says you need to cut down on whether it's salt whatever it is I think they do listen to that sort of advice especially when it's explained to them I think in the language that they are comfortable with, and the affects it can have on them so I think a lot of them do respond to it because I've seen extended aunts that have cut back on salt or they won't have any sugar" (First Generation, Participant 1)

Attitudes towards exercise were similar in the ways in which participants described Indian Punjabi men as being largely disengaged with exercise and physical activity. One participant described how men perceive exercise as a useless activity, which is contributing to the growing rate of prevalence of T2D in the community:

"you have to do exercise to make into muscles, only those people who take part in sports and activities competitive sport they do it, but normal people don't because they think 'well what am I going to do by exercise? Go to compete anywhere?' So everything is what you're going to gain out of it...if you don't exercise and make a good body then you might take part in competitive sport and that is the motivator but if the person can't compete in competitive sport, and I can't do this and do that then what am I going to gain and what is the point? They have different expectations from

what they want to do, and they only do something especially beneficial otherwise they don't do it" (First Generation, Participant 10)

The attitudes men typically have towards food and the importance of taste was also cited as a barrier to good health. For example, participants spoke about the ways in which Indian Punjabi men value traditional foods based on authentic cooking. This leads to the consumption of unhealthy food ingredients such as ghee, fat and sugar, which the participants identified as one of the main factors contributing to the diagnosis of T2D. One participant described the ways in which men are dominated by the importance of authentic cooking, an attitude which has become embedded in the collective mindset:

"and they are giving a lot of awareness now, but taste developed in such a way we are a slave to our taste, and taste has changed or they made to feel so strong about the consequences of these things they might deter them to do these things but don't have sugar" (First Generation, Participant 2)

Authentic traditional cooking was also present in the wider community. One participant spoke about the Gurdwara being a place where unhealthy food is prominent due to the importance of taste, despite increased health knowledge:

"It's happening in the Gurdwaras ... the langars (religious meal) are prepared by traditional people and they put a lot of fat and butter in the saag (spinach based curry) and the sweet and keer (religious dessert) and all that because it's the traditional way of doing it and it's not the healthy for the rest of the congregation to eat but they go ahead because of the psychological effect ... that has to be educated.....yes, it's still happening now, even some of the Gurdwaras have told them not to use that much

butter they said OK but they still do that because it doesn't taste nice ..." (First Generation, Participant 2)

- Psychological well-being and health

Psychological well-being was cited as another factor which contributes to the deteriorating health of the Indian Punjabi collective. One participant described Indian Punjabi men as suffering from psychological disorders such as stress, which they understood to be contributing factors to ill health:

"Yes it is we worry quite a lot, we were not trained to live a life under pressure...and if you are depressed anything can come, so diabetes can come and this is what is happening to half of them and they are suffering because of the family life, it affects a lot" (First Generation, Participant 7)

The collective emotional well-being of Indian Punjabi men was described as 'unhappy'. One participant cited the dissolution of respect for elders as contributing to feelings of unhappiness amongst elders:

"And the other thing I want to tell you is that we are not happy people ... In our age group we are miserable and the reason is because we like respect...I used to respect my father like he was a god and my mother like a goddess and we expect the same thing from my children, and now it's not there but it's not our children's fault because they have grown up here and they've got to do with this culture" (First Generation, Participant 10)

In addition, happiness was also linked with good health, and a departure from it could jeopardise health:

“And if you're not happy you will lose the whole health” (First Generation, Participant 10)

“So to live a good life you have to be relaxed, if the financial situation of the family is not right or if the area is not right I think these diabetics and these kind of people and disorders are more in that group” (First Generation, Participant 5)

The participants stated that there was a need for health-care professionals to recognise of the prevalence of psychological disorders within the Indian Punjabi community and issues associated with it:

“When I say our culture, I mean not your generation our generation. And we do get these papers about diabetes and about high blood pressure and depression, I’m not a professor or anything but a 50% of Asian people, they are suffering from these disorders based not on their diet all their financial decisions but because of their families and what's happening inside their families. Because when they go where the help is available, those people just don't seem and they don't have any experience of Asian culture” (First Generation, Participant 5)

The second-generation participants also acknowledged that the first generation are at risk of chronic conditions such as T2D. They also identified similar characteristics which contribute to health disparities amongst the first generation. The second-generation participants did not identify their own group as one at risk.

- Risky attitudes and habits

Similarly to the first generation, all the second-generation participants spoke about the ways in which the first generation are at significant risk of T2D, and attributed

their increased chances of developing T2D to attitudes held by the group. In addition, the older generation were described as difficult to influence due to their mentality. For example, the older generation were perceived as a group who were 'stuck in their ways' and victim to habits which they find difficult to break away from:

"erm I don't think you can change attitudes of the elder generation, so 60 plus it's very much impossible I think to do that" (Second Generation, Participant 2)

"Because people are very stuck in their ways, and it's hard to break a habit" (Second Generation, Participant 3)

Habits and customs were also cited as contributing to the ways in which the first generation preferred authentic traditional food. For example, one participant described how his mother continues to use unhealthy ingredients when preparing food due to her preferences for taste:

"Because I think she's stuck in her ways and she thinks it tastes better but she doesn't know that something tasting better is worse for your health and she's had cholesterol to tests but they are low but I don't how she managed that, everybody was surprised because whatever she eats she puts butter in it, she puts cheese in it which is quite bad" (Second Generation, Participant 12)

As a result, this meant that food is cooked to taste, as opposed to health:

" I think it comes down to people are stuck in their ways, and a lot of if information is targeting English people, I'm sure there are a lot of elderly English people out there that still cook how they always would have done, before because they are set in their ways of doing that so and obviously there are some Asian people who have taken it on board and do eat a lot healthier, whereas I do think the older Indian generation,

from my own experience that yeah they don't really take into account the ingredients in regards to health it's more about if it makes the food taste really nice... it's traditional it's the way it's always been done and it's remained like that really"

(Second Generation, Participant 1)

When asked to explain why authentic food was so popular, the participants identified a number of reasons. One participant described these preferences as originating from a traditional upbringing in India, where similar dietary practices have been reproduced over time and spatial boundaries:

" erm, I'm not sure I think it's because that's how they were brought up to eat and that's how you cook and they are just set in their ways, for so long if you have cooked in a certain way and eaten a food with certain ingredients and tastes a certain way and then suddenly you start doing start making it different then you know ... and also in the older Indian generation it's still quite conservative and traditional in the sense that it's the woman that's expected to cook when there are large family gatherings so and like a lot of elderly women take a lot of pride in their cooking and the fact that they are good cooks and that they can serve a lot of people and they worry that if they switch the ingredients then there they could be stigmatised in a certain way and people would go away saying ooh the food was horrible do you know what I mean? So I think maybe that's why that's another reason people are stuck in their ways with that in regards to that" (Second Generation, Participant 1)

Another explanation was attributed to the group's collective experience of migration. One participant described the ways in which migration affected the ways in which the first generation consumed and prepared food. In this context, food was a way of remembering life in India and consuming it in the UK was a way of enjoying a piece of home:

“Because it is all they are used to, and they have had years and years of experience of the same thing so it's very hard to continue place and a foreign land and this is alien to them, and they've had to adopt and do everything but the one thing that that they think is that ‘at least we can we can bring our home with us, it is a piece of home when we cook food and that's how I remember it” (Second Generation, Participant 3)

- Exercise and interest

Some of the participants talked at length about the ways in which the older generation are prone to health complications due to their reluctance to exercise. The older generation were described as being uninterested in exercise. One participant stated that any efforts to begin an exercise regime are often poorly adhered to, and diminish over time:

“no way they talk about it but they don't do it ... I don't know why don't do it, maybe they think they are not bothered or maybe they think it's too late... Like my cousin's mom she kills it at the gym and his dad and they've been doing it for a long time and maintained it but they are in love for the one keep healthy for each other” (Second Generation, Participant 13)

One participant described how the collective community perceive adequate exercise as being achieved through everyday life. One participant described how exercise is not part of everyday discourse for these men, and is devalued as an unimportant activity:

“So a lot of things are quite small and common sense, so make sure you have five fruit and veg and probably the worst thing for South Asians is exercise, they think

because I've gone to work and do manual work it is a bit of exercise, but it's not that exercise at all...gyms are free it's not a financial burden any more that you have to pay extra money and you might be struggling in a recession but you can still do it ... I think if people come from India and start businesses and have big houses and good cars they can do anything. Basically they're not exercising because they don't see any value in it and how it benefits them... if I can take a tablet or go for a walk, it's easier, it is the same thing but with less effort that's the principle people have and South Asians have that. It doesn't have any values for them in terms of exercise or they don't see the value" (Second Generation, Participant 5)

The same participant described why elders tend to be more reluctant to exercise due to the negative impact exercise has on identity. He explained that the perception of doing exercise or being seen exercising was detrimental to one's self-identity as exercise is considered to be in opposition to living a carefree life:

"it's a big stumbling block it's almost like embarrassment that we are doing exercise and looking after our health, not been carefree... it's like if you ask some women and they said they won't walk because neighbours might see them and what would they think, never mind you might die five or 10 years earlier but as long as the neighbours are happy" (Second Generation, Participant 5)

- Denial and health

The first generation were also described as being in denial about their health, and a group who do not perceive to be at risk of illnesses such as T2D:

“Yes it's like ignorance is bliss...It won't happen to me. You know I mean? To a degree, I think there is so much variety and options all go on then, I will do this or I will try this, you only live once” (Second Generation, Participant 3)

This attitude of ‘being in denial’ was described as having negative consequences for the community’s health, and denial was born from a fear of wanting to stay unaware of health implications:

“Yes it is because if there is something wrong do they want to know what's wrong with them and facing up to it ... Because maybe if find out something is wrong with them they have to stop what they're doing because and they don't want to stop” (Second Generation, Participant 7)

“Well it depends I don't know, I think he wants to go to the doctor because he doesn't want to hear bad news and probably doesn't want someone telling him what he should do what he should do and how he should control his diet” (Second Generation, Participant 9)

- Masculinity and health

Participants also identified first-generation men as being in poor health due to their perception of masculinity. One participant cited the ‘male ego’ as an influencing factor on how Indian Punjabi men perceive health care professionals:

“I think that's difficult with Asian community because my dad although, he is health-conscious and the how to be healthy, he won't go to the doctor. I don't know maybe it's an ego thing? Actually to be honest I think is afraid to go because he knows the doctors will tell him something like your blood pressure is too high and you've got to

stop certain types of food and the doctor will tell him the usual cut down on the drinking when you have cut down already and then why do it?" (Second Generation, Participant 9)

Illness and being seen in poor health were also perceived as damaging to one's social masculine identity. For example, one participant spoke about the ways in which illness and the effects of poor health have social repercussions for the first generation and their standing in the community:

"I think culturally if somebody is ill or weak or fragile or seem to be any of those things they look down upon you, your social status decreases and you're not seen as someone who is a fully functioning person in society so your value decreases or you're pitied on" (Second Generation, Participant 5)

Masculinity also meant engaging with risk-taking behaviours. Many of the participants spoke about the ways in which the consumption of alcohol is closely associated with maintaining a masculine identity in front of others:

"well basically if you want to be a bloke you have to handle your drink if you're a man or whatever that means ...Just because you can take your drink at the end of the day nobody can keep drinking" (Second Generation, Participant 13)

"They see it as something different to say, like you are more masculine like more of a masculine person" (Second Generation, Participant 7)

"I think it's probably an issue with masculinity, it is being seen as the one that can drink the most is the alpha male" (Second Generation, Participant 5)

Summary

Identity and masculinity play a significant role in the health practices of these men. The importance of maintaining a masculine identity is entwined with the appearance of good health. The meaning of masculinity and how maleness is interpreted amongst Indian Punjabi men is closely associated with hegemonic masculinity, which has had damaging consequences for health. Shared attitudes of the collective are also seen as inhibiting good health practices alongside psychological disorders. These findings emphasise the complexity of the barriers to health for these men.

- External factors contributing to health; social peer pressure

First-generation participants

Peer pressure within the Indian Punjabi culture was described by the first-generation men as encouraging irresponsible health behaviours such as heavy drinking. One participant made a direct comparison to the Western drinking culture where the pressure to drink is not as prominent:

“if there’s ten of you sitting around a table and 9 of them are drinking and you’re the one there sitting with an orange juice you know, come on have a drink and it’s that kind of pressure, and you do succumb to it it takes a very strong-minded person to say no! Like I said, you’ve got to know your own limit and draw the line” (First Generation, Participant 1)

“but it’s a lot of peer pressure especially in our culture, if I go out with my English friends there’s no pressure, you can drink what you like you can have a glass of water” (First Generation, Participant 1)

Similarly, social groups and the influence of others were stated as influencing health practices. The same participant described the ways in which the consumption of alcohol and drugs is often promoted by social groups and acquaintances. In this context, the family play a part in negotiating individuals on to the right path away from irresponsible health decisions:

“it’s the social circle or the friends they have got that they are living amongst and they tend to drop back into that again and it’s very easy for them to drop into it if they want to quit it then they have to totally move away from that circle, totally and it’s very difficult for a lot of people because it could be that they can’t afford to, could be family nearby or they don’t want to because the biggest thing is the onus is on the person if they are strong willed enough they will move away ... if they are not getting that support from their family, everybody needs support I feel now they are not getting it from the family” (First Generation, Participant 1)

Excessive drinking amongst Indian Punjabi men is also reinforced by popular culture, specifically traditional Indian music (Bhangra music). One participant cited the lyrics of a popular Bhangra song, which encourages drinking amongst men:

“well here of course the culture and especially this Indian pop music and Punjabi Bhangra songs they glorify it. They know very well what damage it is doing deal it’s being glorified in our songs and I’m sure it doesn’t help. You hear the songs in the wedding songs, all these songs are about drink and food it is isn’t it?! There are some songs to do with alcohol – ‘have a drink and I’ll put you on my shoulders’ - yeah it is, you hear the music played at weddings and at my son’s wedding. The songs are

there ... it's a part of a culture that doesn't mean people have to drink but sometimes it makes you think that way" (First Generation, Participant 6)

- Environment and health

The environment also contributed to the poor health of the community, as participants made comparisons between the quality of life in India and England. Direct comparisons were made about the living conditions between the two countries, where the standard of living was significantly higher in England compared to those living in India:

"Why do they live longer? Because of the climate factor and the food. I don't know whether you have been to India, it's not exactly what it should be because you have so much pollution open sewers and this and that and when the people come from India to here, and they live a longer life simply because you have eliminated those factors that are associated to damage" (First Generation, Participant 6)

The environment was also spoken about in terms of the differences in pace of life in India and England. India was described as being associated with a slow pace of life in comparison to the busy lives led by those in England. The relaxed pace of life of India is seen as existing in conflict to the changes experienced in England and contributed to the ways in which those who migrated felt the pressure of this new environment which contributed to stress and worries:

"And living in a controlled environment but over there we used to wear what you want to walk around but here you can't do that, over there you can sit under the tree, here you can't do that. So in a way we came from an open environment more or less, and

we were peaceful quiet people and then you become involved in that society, plus the worries that came with supporting everything else added to the pressure” (First Generation, Participant 7)

- Lack of health education

The poor health of the community was also attributed to their lack of health awareness and access to health education. Lack of awareness was described as originating from a lack of education during their time in India, where there were limited educational opportunities to learn about health and illness:

“We were naive on those issues because nobody taught us” (First Generation, Participant 7)

“But over here you get this kind of education in schools, in India there was no such thing. There was no mention of diet or what is good or how much you should eat your anything like that. So it goes back again to where you were born. Over here in the schools I learnt things. But in India, nothing” (First Generation, Participant 5)

“Because people didn't do things to keep healthy they didn't realise that exercise was something that is something necessary, it's an education about how our body works they are not aware of that that if you eat well your body becomes good, so they kept the same diet, and there was ignorance as well and no awareness of these diseases such as diabetes nobody knew about it” (First Generation, Participant 10)

When asked to explain the lack of health awareness, limited access to formal education also hindered an individual's capacity to identify illnesses. The same participant described how individuals would die from symptoms of the disease

without full realisation of their diagnosis:

“Yes it was, I think people didn't really know. I'm sure in those days when I was very young some people use to get a cut in their foot and never heal and because they did things barefoot not having shoes, people used to get bacteria which would get into the cut and if they had legs to be amputated some people would die from that kind of thing, it was not recognised as diabetes” (First Generation, Participant 10)

This lack of health awareness is only described as being characteristic of the first generation. The second generation were described as practising better health behaviours due to the fact that they are more educated, which has resulted in an increased awareness of health amongst their group:

“do you think there will a difference in the second generation?”

“I don't think so, they are different they are more educated and aware of what's right and what's wrong and they understand the consequences of bad food” (First Generation, Participant 2)

“but your generation is much better and like my grandson, he should know everything. Although he's thinking will be different but health wise in education his thinking of issues that will be different than mine” (First Generation, Participant 7)

Second-generation participants

Similarly to the first-generation participants, the second-generation participants also identified lack of health education as a contributing factor to the poor health of the

older collective community. A number of participants cited a lack of access to formal education and subsequent lack of knowledge as a factor for their increased awareness of health:

“erm ... I can’t give any occurrences, I think it comes down to education again. I would say just a lack of understanding and so called theories about what’s right for the body but not necessarily it might not be, yeah so education again” (Second Generation, Participant 2)

“It's more about awareness and education you don’t have to be educated to change your behaviour and to realise what you're doing is appropriate you don't have to be able to read English or have an academic education ” (Second Generation, Participant 5)

“ to be honest I don’t think a lot of them understand ... their health as such and what’s good for their body and not ... as individuals I don’t think they understand at all, or even as a group for that matter” (Second Generation, Participant 2)

“because with education obviously comes learning, so they would understand what’s good for the body and what’s bad and a lack of that, unable to read or write English or read or write for that matter, they are unable to educate themselves about what’s correct food and what’s food for their bodies” (Second Generation, Participant 2)

Participants also spoke about how the first generation are unfamiliar with the risks associated with T2D as symptoms often manifest unbeknown to the sufferer. For example, they explained that it is only when symptoms produce physical changes in the body that the seriousness of the condition is acknowledged:

“a lot of chronic conditions are not visible you can't see T2D, it's something that's internal, someone can't see it doesn't exist and you don't have to think about it, it is still present in people but unless somebody really has a real deformity of physical deformity, like if they've got T2D and that leads to an amputation then that will make them realise that this is my diabetes” (Second Generation, Participant 5)

“health wise people don't do anything unless something happens too close to them or someone says it abruptly but some people don't care like smoking, some people don't care” (Second Generation, Participant 13)

“They will probably learn that as life goes on but not until they are at the last stages of their life until they realise they ate too much or drank too much” (Second Generation, Participant 2)

Only a few of the participants spoke about the benefits of health education. One participant spoke about the ways in which the older generation are considered difficult to influence, whereas the younger generation are considered to be more susceptible to changing their health behaviours:

“erm I don't think you can change attitudes of the elder generation, so 60 plus its very much impossible I think to do that but I think with the younger generation ... I think in theory they should, cos it's quite high in Asian men in theory they should realise that as a result they could be prone to it as well and found out more information themselves, and in an ideal world and counter attack it and make sure that they are on the right the right diet, exercise and having that advice early rather than later. But the only people you can kind of get that information out to is going to be people that are 25, 20 plus now, not the elder generation” (Second Generation, Participant 2)

In addition to this, the younger generation are considered to be more knowledgeable about health in comparison to the older generation due to their increased access to education:

“I think now, people my age are a lot more educated” (Second Generation, Participant 2)

Summary

The findings show that both groups draw upon a number of wide and varying theories to describe and explain health disparities amongst the Indian Punjabi community.

These sets of complex lay theories exist in parallel to the biomedical scientific model, as explanations of risks are based on life experiences and narratives of the men within their everyday lives. These findings are essential to understanding the causes of health risks, as a comprehensive understanding of the lay theories which come to explain health risks have important implications for individual health behaviour. The following section will explore how the men spoke about witnessing others such as family suffer from illness and the implications this had on their own risk perception.

5.1.5 Risk perception (ii): Perceptions of family illness and risk awareness

The literature has identified that for common diseases, such as T2D, having a close affected relative is a predictor for an individual's risk of the disease as witnessing the disruption of health in others can increase awareness of risk in the self (Walter et al., 2006).

This section describes how participants spoke about their experiences of witnessing family members cope with illness and the affects it had on their own perceptions of health and risk (see Table 16):

Table 16. Data summary: Risk perception (ii)

	First generation	Second generation
Risk perception (ii)	<ul style="list-style-type: none"> • Perception of family illness and risk awareness 	<ul style="list-style-type: none"> • Perception of family illness and risk awareness

First-generation participants

Participants spoke about their experiences of witnessing family and friends suffer from a wide range of conditions such as T2D and heart disease, and the impact it had on their perceptions of health risks. Only one participant spoke about his family history of T2D, and how it had influenced him to become more informed about the disease, which ultimately led him to modify certain health practices:

“they say you're more likely to get it when both parents have it, so yeah, we will see but the main thing is I've tried to control my weight and exercise and keep fit as much as possible” (First Generation, Participant 10)

For some, seeing others suffer often brought the consequences of such illnesses to the forefront of their awareness, and led them to contemplate their own health. One participant described seeing a friend suffer from heart disease and T2D, and the subsequent awareness it brought to his health. As a result, the incidence of disease

in others was a prompt, which encouraged self-reflection about potentially damaging health behaviours:

“I think it’s starting to change because I suppose if your friends been ill whether it’s a heart problem, diabetes, you’re more aware of it, if it’s not happening around you don’t tend to focus on it, it’s not something you’re interested in but if it happens to someone who’s close to you, all of a sudden you start to take an interest, whether it’s high blood pressure, you know the causes and you take more of an interest and I think if it happens to someone closer to you, it’s more likely to change the way you’re living as well” (First Generation, Participant 1)

This was also common for other diseases such as alcoholism. One participant spoke about witnessing family members become addicted to alcohol and how this influenced his perception of alcohol from an early age:

“In terms of illness, I have known alcoholics, we have had a few in our family, so you know what excess alcohol can do to you, from a being a younger age I knew if you drank too much it’s not good to you” (First Generation, Participant 9)

For some, witnessing illness in others prompted lifestyle changes. One participant cited his mother’s heart attack as a point at which he began to modify his lifestyle and dietary practices, such as removing butter and oil from his diet, which he considered to be a contributing factor to his mother’s episode:

“I am more aware of it since after my mom had a heart attack so we became more aware of issues with eating, so not a lot of fatty foods and no cooking with butter because you know a block of butter or half block butter is not good idea any more but I’ve changed the way I do my cooking, like I use olive oil for most things are like in

Chinese, I would use a lot of groundnut oil but it's very minimal" (First Generation, Participant 9)

Nevertheless, seeing others ill did not prompt all the men to reflect on their health.

One participant described how witnessing a relative undergo major surgery due to cardiovascular complications, had little effect on how he perceived his health.

Although his awareness of health risks are high, he described himself as an optimist, which facilitated his ability to maintain good health:

"Well my brother-in-law the other week he had a bypass operation the other week, and it didn't affect me in that way, I thought poor guy it's a shame what his family will have to go through, because it's not an easy operation to have, but it didn't occur to me that it might happen to me. I don't have that sort of outlook ... I mean you learn things by watching House on the TV and you know a bit about diseases and medical terms but I don't think it will happen to me. I suppose I'm an optimist in that way" (First Generation, Participant 9)

The physical appearance of other individuals also had an influence on how some perceived illness. One individual spoke about the ways in which illness is visible on the body, and premature ageing is one indicator of poor health:

"I would say it's a similar sort of age group to myself, I look at certain people, you're chatting to them and they are a very similar age to yourself but you see them as a lot older if you see what I mean" (First Generation, Participant 1)

Second-generation participants

Similarly to the first-generation participants, second-generation participants spoke about the effects of witnessing family members suffer from conditions such as T2D, high cholesterol and alcoholism. Many described how seeing others manage their conditions significantly raised their awareness:

“in all fairness, I don't think I would have had as much awareness as I have of it, maybe I would know about it over time and make conscious efforts to stop but I do think the awareness would not have been as bold as it is” (Second Generation, Participant 3)

“I've seen what happens ... to my granddad and his foot and it's gone gangrene so I've seen the effects of it and what can be done” (Second Generation, Participant 13)

“do you think about health in terms of how there have been instances in your family of diabetes or cholesterol?”

“yeah ... My uncle and my grandma”

“do you think that's made you think more about these things?”

“yes it has because it makes me stop now and again when I think they are diabetic maybe I need to calm down” (Second Generation, Participant 7)

One participant explained how coming from a family with a history of T2D influenced his health decisions:

“so it's something that plays in the back of your head and especially if you are from a family where there is a history of diabetes, so put extra emphasis on it, so you're always thinking that maybe I should cut down” (Second Generation, Participant 3)

For the same participant, seeing family members suffer from T2D prompted him to alter and reevaluate his lifestyle habits in order to reduce his own threat of developing the disease. For example, he managed his intake of specific ingredients such as sugar and salt after his grandmother's diagnosis of T2D:

“every member of my mum's family is diabetic apart from my mother. So I sat down with my mum and said let's be proactive not reactive we have an advantage, so because of that I have cut down on my sugar, I do take sugar in tea, I try and cut as much salt as I can but that is my weakness, so I think there is a fine line that should be drawn ... I'm not saying cut everything out altogether but look where you can compensate and we can't ... So if one has an option to try to substitute you should” (Second Generation, Participant 3)

Another participant described how his father's diagnosis of T2D had raised his awareness of the disease and prompted him to manage dietary intake of specific foodstuffs such as sugar:

“It's made me aware of it but before that it never really crossed my mind I would never think I should need that because I had too much sugar today and everything about things like that I still don't but now it's a little bit more controlled” (Second Generation, Participant 9)

For another participant, his mother's diagnosis of T2D influenced how he became aware of the disease at an early age, and this knowledge facilitated the change of certain health behaviours relating to dietary practices:

“Probably at the time I was only about 10, so I didn’t really realise what she had, but she was quite aware that she needed to do something about it so basically she did in terms of diet and exercise we all did something about it so basically at that age, through what you eat and what you do but it was mainly that as soon as she realised I read information through the doctors and GPs it changed her diet radically, and some things I take for granted like eating wholemeal bread, not putting salt on your food, not having sugary cereals having Weetabix or porridge, we used to get home and she used to make us eat loads of fruit and say if you want junk food you can have it after your evening meal and we had loads of fruit after the evening meal you’re full so she did those tricks on us and you only realised when you get old that’s what you did”

(Second Generation, Participant 5)

Changing behaviour and health practices as a result of witnessing others suffer from diseases did not only apply to chronic conditions, but was also spoken about in reference to alcoholism. One participant described how his father’s alcoholism reduced his own consumption of alcohol later on in life due to the devastating effects it had on his father:

“and with my health and my dad passed away from alcohol poisoning, I drink more fruit juice and stuff like that and if we go to the pub and if somebody has a beer I will have a non-alcoholic unless it’s a special occasion like a stag do or a birthday then have a drink then” (Second Generation, Participant 12)

Nevertheless, only one participant disregarded T2D as a potentially harmful disease, despite close family members suffering from the condition:

“I do have some relatives, my uncle who passed away, nothing to do with diabetes but he was diabetic I do have another relative actually who is diabetic but apart from

that I don't know anybody with diabetes ... I don't think about diabetes, I haven't thought about it" (Second Generation, Participant 1)

Summary

Unless individuals regard a condition as serious, they are unlikely to take preventative action to avoid it. It becomes apparent that amongst the second generation, witnessing others in ill health had a greater influence on their own health and raised their awareness of conditions such as T2D as a serious condition. Second-generation participants appeared to be more affected by the health condition of others, which prompted more behavioural changes compared with the first generation. It could be suggested that the second generation are more likely to be affected by the ill health of others as they have been brought up around elders who have had these conditions for a long duration. Despite recognising the prevalence of T2D in family history, first-generation participants failed to increase their awareness of diabetes risk.

5.2 Part Two

This part of the chapter describes the topics that the first and second generation spoke about individually. Whilst both the first- and second-generation participants perceived the health of the Indian Punjabi collective as at risk, only the first generation identified possible interventions in the form of informal learning via family members and formal health education delivered by health-care professionals in the

community. The second-generation participants were the only ones to talk about exercise, football, smoking and drug use. Table 17 provides a summary of these topics:

Table 17. Data summary Part Two

First-generation participants	Second-generation participants
<ul style="list-style-type: none"> • Learning in the family • Formal health education in the community 	<ul style="list-style-type: none"> • Exercise and football • Drugs and tobacco use

- Learning in the family

First-generation participants

Some participants spoke about the benefits of learning about health from family members, such as offspring. They considered the second generation to be more knowledgeable about health, and were often called upon for health advice:

“Well obviously they have got to be made aware of it, awareness will come through different sort of modes in different ways I think if you put emphasis on children, see what I mean, because parents would listen more to them than anybody else” (First Generation, Participant 10)

“Because the younger generation went to school and college and learned these things, and brought back their knowledge and passed it on so if somebody said to them they would know about diabetes and the causes and symptoms and if somebody said am feeling a bit rough today, they would say after something about

that why do you go to the doctor's and have it tested?" (First Generation, Participant 9)

The formal education that their children received in school about health and health practices is being utilised by elders in the family. For some, relying on children's lay knowledge was already cited as a successful method of raising awareness and changing behaviours:

"I was struggling until my daughters came along, but the youngest daughter she taught me a lot of things. And this is where picked it up from" (First Generation, Participant 7)

For other first-generation participants, formal health education was identified as the most useful method by which health awareness could be raised in the community. Participants spoke about the importance of key places in the community for the delivery of health education, such as Gurdwaras and community centres. For example, some of the men highlighted the potential influences religious leaders have in passing on important health messages to the community:

"if I was to set it, it would target the biggest congregation of the Asian community on a Saturday or a Sunday, some have got classrooms, so for kids to teach them the culture and the language and I think that would be the ideal place to target and you are likely to catch more of an audience than anything and especially if it's put across by the head person at the Gurdwara and I think people are more inclined to listen that's the best target for me, outside of actually picking them up from their houses! Because I think a lot of the older generation do still go and listen to the leaders" (First Generation, Participant 1)

“so maybe people at the temples can have talks and give talks on depression, diabetes and yoga classes so people are becoming more aware that's being driven by the older generation, because they've had those complications either themselves or their family all they know somebody” (First Generation, Participant 10)

Participants also cited the importance of the social features in the community. One participant explained the advantages of utilising social meetings as a way of generating knowledge between people. The coming together of groups was seen to be beneficial to facilitating story sharing and improving health awareness amongst individuals with similar health issues:

“I think education is very important, it doesn't matter what it is, whether it's health issues or monetary issues, it doesn't matter what the issue is, if education is there it's going to improve awareness straight away and only if you only change one person out of ten, it's had its desired effect, that's what you're looking for, like I said a lot of the older people are suffering with all sorts, and I think diabetes is one of the biggest things in Asian cultures, and when there are a group of people together and they have these ailments they tend to talk amongst themselves there is a bit of empathy with each other, and I think that has a bigger effect, you can still put the message across but when it's amongst the group in a social environment it's likely to educate people and hopefully improve but when you do see people suffer like this I think that has a bigger influence in terms of health wise, and you do change your ways, but some people don't” (First Generation, Participant 1)

When talking about the need for formal health education, participants identified the first generation as being the main target audience. One participant went further to identify Indian Punjabi women as most in need of formal health education. As women are usually the main caregivers in the family unit, they would benefit the most from

learning about the health implications associated to certain dietary practices:

“I think it’s education, it is the one thing and above all ... educating families especially the ladies in the house they should be made aware of the consequences of bad food, fat, sugar and that kind of thing” (First Generation, Participant 10)

Nevertheless, the benefits of formal health education seem to exist in juxtaposition with other conflicting messages in society. One participant described the unbalanced relationship between scarce health education in a society which simultaneously promotes unhealthy practices. For him, health education is undermined by the public promotion of contradicting health behaviours such as alcohol and smoking:

“I don’t know I think it’s the society as a whole, it’s a conflicting message I mean yes they are aware it’s their health, also conflicting messages and a lot of things are promoted which are bad for your health like alcohol is promoted in a big way smoking used to be in a big way, and fast-food convenience food is promoted in a big way. So you’ve got a little bit of education, then a great deal of temptation” (First Generation, Participant 8)

Not all of the participants cited health education as being the only way to improve health awareness. One participant stated that the Indian Punjabi community are still receptive to health-care professionals, and can still be approached through formal methods such as letters and appointment requests:

“sometimes it’s worth writing to all men and women for a routine check-up just to check their sugar levels because they will ignore it as much as possible because they will and people who don’t come a reminder six months later and I think they will catch

it early on, rather than developing this disease and treating it, sometimes it can be avoided that if you reduce your way to a certain level you can avoid this and that an incentive and check six months again” (First Generation, Participant 10)

- Exercise and football

Second generation participants

The benefits of exercise to health were recognised by participants, and their participation in sport was mainly for enjoyment purposes:

“in regards to health and diet and exercise ... I think it is really important to eat healthy and exercise, I do exercise myself I guess I could eat a lot more healthily, people I know in my family of a similar age group to me do a lot of exercise obviously the elder people in my family are a lot older they don’t really do exercise they walk so I would say exercise does play a role” (Second Generation, Participant 1)

“I think you should exercise regularly and I think it’s very very important in life that you should be active and doing something physical it’s very important” (Second Generation, Participant 2)

“I do quite a bit of exercise, I play football I play tennis....

“so do you do that for enjoyment?”

“Exercise and enjoyment both to be honest” (Second Generation, Participant 7)

Exercise was cited as the best way for managing weight gain, yet the reasons for doing exercise were aesthetic. The importance of losing weight was not associated with reducing biomedical risks to health, but primarily for improving/managing

physical appearance:

“I don’t know why (I have been exercising) I think it’s... I can only talk about my experience, but recently in the last year I’ve been putting weight on” (Second Generation, Participant 13)

“I didn’t do any kind of sports throughout the whole of university life even then I would consider myself is quite healthy I was putting on fat but it was just recently now that I’ve started to realise that put on a bit of weight so I need to start working out and take care of myself” (Second Generation, Participant 9)

Commitment to exercise was also sometimes facilitated by extraneous factors. For example, one participant described the ways in which men will often join a gym after a break-up of a relationship or a derogatory comment about their appearance:

“Yes because one of the guys joined the gym because he broke up with his fiancée so he thought I need to channel energy into something and he hit the gym a lot so there’s a reason like when they have been called fat and they want to change their life around” (Second Generation, Participant 13)

Nevertheless, participants identified the difficulties in committing to a regular exercise regime, due to time constraints and work commitments:

“I’ve told him (father) to join a gym with me, but it’s his time he’s got to go to work. I work at different times and joining, finding time to go is the issue” (Second Generation, Participant 9)

“I didn’t used to eat that much, used exercise a lot, I used to play football four times a week and kept everything on an even keel and because I started job and it’s such a long commute, you’re on the go all the time I’m tired by the time I get home I eat and go to sleep” (Second Generation, Participant 13)

“No I don’t, I know I should but I don’t, but then again that’s because of work, I’m so busy with work it’s been constant nonstop for the past few years so that’s my excuse, I have had no time” (Second Generation, Participant 4)

Many second-generation participants spoke about exercise and the role it played in their lives, especially football. Football was a popular activity, primarily played for enjoyment and socialising with others, as opposed to the potential health benefits. This section describes how participants spoke about the importance of football, and two themes emerged: enjoyment and competition. Participants described playing football for enjoyment, and spoke about the importance of being healthy in order to play football:

“at university? No way, you used to get together and it was a laugh but no nobody used to think about health really ... I think for me it’s because I’m getting slower at football and need to do something to make sure I keep my speed up because I can’t let these people think they are better than me” (Second Generation, Participant 13)

“It’s for fun really we have a laugh when we get together” (Second Generation, Participant 8)

One participant assessed his health through his capability to do well in football. Being ‘unfit’ is perceived to go hand in hand with playing slower than usual. Here, the concern is not necessarily with health, but instead with the ability to perform well in

football:

“but when I used to play football I was slower and you feel out of breath and one of the things I felt recently I was out of breath so I got my asthma checked and it was getting worse so I do swimming more because it’s better for that” (Second Generation, Participant 13)

Competitiveness was cited as an important value of football, which is seen to be the driving force behind the men’s participation. In addition, football was also cited as a useful way of socialising with others:

“Both because it’s for enjoyment and it’s exercise and I get to socialise with my family because everybody is working so the bonding occurs and sometimes you have energy and competitiveness but you get a certain voice that I will snap will be competitive” (Second Generation, Participant 12)

“But I tell you if it wasn’t for football we wouldn’t be as close as we are ... it’s bonded all of us cousins and friends definitely because my uni mates they are close with all of my family through football because they are into football and we all used to play together ... It’s all through football is started at university...so it’s a social aspect to it” (Second Generation, Participant 1)

The topics related to exercise and football were unique to the second-generation participants due to their age. Nevertheless, the values attached to exercise were not necessarily linked to health benefits or the management of health risks.

- Drugs

Only one participant referred to the use of drugs, and explained how some drugs are perceived to be more damaging to health than others:

“Yeah like cocaine is more extreme to them in comparison to weed I think there's different types of levels” (Second Generation, Participant 7)

Additionally, the health implications associated with drugs and alcohol were described as being perceived in stark contrast in the Indian Punjabi culture. However, the participant considers them both as possessing the same effect on health:

“Yes drugs are seen as more serious than alcohol even though it's the same I think, it's like tradition and religion and that but that's like alcoholism it's not really allowed is it?” (Second Generation, Participant 7)

- Smoking

There was evidence of a cultural shift in attitudes towards a different practice: smoking. Participants spoke about the social taboo attached to smoking within the Indian Punjabi community and how it is deemed as unacceptable in contrast to drinking:

“Indian males can have a drink they go out and they go to the pub and even smoking has quite a taboo kind of thing with that...I think the older generation they don't smoke and it's frowned upon” (Second Generation, Participant 1)

“That's where the misconception comes in, like, drinking, everyone does it, it's not that bad in moderation ... cigarettes no no no ... I think they see it as the big no no ...

it is the misconception it is the one thing we should stay away from” (Second Generation, Participant 3)

There was an acceptance that there are differences in the ways in which smoking is perceived in comparison to alcohol due to the characteristics of smoking, which is perceived as a dirty habit:

“and stuff but smoking for some reason is still being and seen as something really bad, to be honest I’m not sure why it can’t be down to religious purposes I guess because if people were so religious I guess they wouldn’t be drinking maybe it seems as being more unhealthy, yeah the only thing I can think of is it comes down to health really people saying it’s unhealthy or it’s seen as unhygienic or being dirty” (Second Generation, Participant 1)

“absolutely, I think it is seen in a bad light as in, which it should be, but it’s seen as a very dirty thing to do ... for smoking I think, that we can go out drinking ... but smoking I think smoking is more of a taboo because the smell of it, I don’t really know why people frown upon smoking as opposed to drinking” (Second Generation, Participant 3)

When explaining how smoking has become socially unacceptable within the south Asian community, one participant cites how the older generation have misconceptions about smoking and often link it to drugs:

“it’s more of a chemical reaction and maybe people, the older generation haven’t been as clued to it and what it actually is maybe they think it’s drugs, they don’t know what it is, it’s misconceptions and misunderstandings” (Second Generation, Participant 3)

Summary

All of the participants had previously identified the first generation Indian Punjabi collective as being unaware of health risks due to the lack of formal education made available to them. The importance of learning and being educated about health was discussed by first-generation participants. For some, this meant learning about health via their children. Children and their lay knowledge of health had been identified as a legitimate source of health information for many of these men. This could go some way to explaining why some south Asian men are reluctant to seek medical advice from health-care professionals if they are seeking guidance from family members instead.

Formal health education was seen to be most effective when delivered in the community, which reveals that this group might not be comfortable with engaging with health-care professionals in a traditional medical/clinical setting. Place was important in the context of health education, as key places in the community were identified as being most appropriate for the delivery of health education. These places could have been identified due to their appropriateness in overcoming accessibility issues and language barriers for users in the community. Drawing on the social aspect of the community was cited as a good way of facilitating talk and storytelling with others with similar health experiences, and another way of raising awareness about health. In addition, if formal health education is to be successful within this group, it needs to become prominent and overthrow conflicting messages about unhealthy practices. The first generation are not considered to be completely unreachable through traditional methods, and are still open to health-care

professionals. This suggests that methods of raising awareness through primary care practices should continue alongside community efforts.

The second-generation participants did not talk about formal health education for their generation. It could be argued that this is due to the fact that they do not see themselves as a group at risk of T2D. This is a particularly revealing finding if health-care professionals now want to target those from south Asian populations at younger stages of their lives. Instead, the second-generation participants spoke intently about exercise and the benefits of losing weight for aesthetic reasons. This suggests that for these men, physical activity is considered not in terms of the direct health benefits, but in terms of what can be achieved in terms of physical appearance. Additionally, football is played for enjoyment and acts as a way to maintain social relations with others. These findings suggest that these kinds of physical activity might only be appealing to second-generation migrants, which could inform how health-care professionals might want to promote healthy lifestyle changes for this group.

Finally, only the second-generation participants spoke about the recreational use of drugs and smoking within the Indian Punjabi community. Both are considered to be taboo within the community, and are activities which are particularly frowned upon by elders.

The next chapter examines these findings in relation to current knowledge, and highlights the potential contribution they have for policy and practice.

CHAPTER SIX: DISCUSSION

6.0 Introduction

This research study set out to explore the social and cultural factors which influence Indian Punjabi men's health beliefs and perceptions of risks related to T2D. The aim of the study was to address the gap in T2D research about Indian Punjabi men's health beliefs and risk perceptions of T2D in order to inform educational and lifestyle interventions for this group. The study was developed following an initial review of the T2D literature, which showed a lack of evidence on the health beliefs of Indian Punjabi men.

The study aim was achieved through the two research objectives:

- To identify and explore the specific cultural and social practices which shape Indian Punjabi men's health beliefs
- To explore how the risk of T2D is perceived amongst Indian Punjabi men

This chapter begins with a discussion of the findings in relation to the two research objectives and existing literature. Following this, the significant contributions this study has made to existing research, practice and policy are addressed. The chapter then goes on to explore some of the limitations of the study, along with recommendations for further research and ends with concluding remarks.

6.1 Discussion of the findings

The main findings of the study were summarised in Chapter Five. This part of the chapter synthesises the findings to answer the research objectives. The findings will also be explored alongside the wider context of the literature in which it is located.

- To identify and explore the specific cultural and social practices which shape Indian Punjabi men's health beliefs

The men's perceptions and beliefs about the eating and drinking behaviours of the community were shaped by social and cultural practices common within the Indian Punjabi community. The following section explores the influence of hospitality, which impacted on how Indian Punjabis eat in social settings. Discussion will then move on to examine the men's perceptions of the cultural and social norms that influenced drinking practices in the community.

6.1.1 Hospitality

In this study, the cultural significance of hospitality is emphasised by the socio-cultural meanings ascribed to food and alcohol. In the social setting, food and alcohol function as social markers, which indicate a 'successful' status to others in the community. Food plays a crucial role in the identity management of the host, who will offer elaborate servings to guests as a way of asserting their success to others. The cultural link between food and status has also been found elsewhere. For example, in

the Bangladeshi community, the serving of 'everyday' foods to guests carries social repercussions for the host (Grace et al., 2008).

The role of food in south Asian identity reproduction has been discussed elsewhere (Harbottle, 1996, Das Gupta, 1997, Jonsson et al., 2002; Sahoo, 2006). In this study, the importance of food and its relationship with identity could be explained by how food acts as a poignant reminder of the homeland for Indian Punjabi migrants. It could be suggested that food is consumed as a "visible sign of their ethnic identity" (Lessinger, 1995; 32). It could be argued that for the first-generation men, their identity has been challenged in new environments following migration, due to a loss in shared territories which has intensified the shared ethnic identity (Jenkins, 2004; Bhabra, 2006; D'Sylva, and Beagan, 2011). Therefore, the preservation of their identity is done through the reproduction of culture and, in this case, traditional food practices (Beoku-Betts, 1995, Das Gupta, 1997).

For the men in this study, food and alcohol are important social and cultural resources, which refer directly to power and status. Therefore, food and alcohol function as forms of social capital, which are used by the men to build and sustain social ties. The use of food and alcohol as social capital to facilitate social cohesion and social mobility has also been found elsewhere (Bourdieu, 1986).

The findings in this study support the observation that cultural meanings are attached to social eating practices and identity construction (Fischler, 1988; Mennell et al., 1992; Sandhu, 2009; Chapman et al., 2010). In addition, the findings echo what has already been found out about food and practices and hospitality in other south Asian groups. As mentioned in Chapter Three, food practices play an important role for

Kashmiris and Bangladeshis during times of celebration (Naeem, 2003; Grace et al., 2008). There are also some similarities with the 'lavish hospitable meal' (Bush et al., 1998), which differs from everyday foods in that it is celebratory and served in large quantities. Similarly, to the men in this study the health implications of these offerings were rarely considered by either guest or host (Bush et al., 1998). However, one exception emerged from the findings of this study. For Indian Punjabis, the 'hospitality culture' is not restricted to times of celebration, but applies to any social gathering when guests are present. It seems that in the Indian Punjabi culture, hospitality functions according to the norms of communality and 'gift exchange' (Murcott, 1982, 1983). For example, honour was a central concept of hospitality for the men in this study, which has been described in the literature as the practice of 'lena-dena' (gift giving to guests) (Bradby, 2002). In this study, food is an intrinsic part of the 'lena-dena' system and is a dominant characteristic of Indian Punjabi social life.

The findings presented in this study make a new contribution to knowledge in this field, especially in relation to how the men spoke about the 'transformation' of hospitality over time, which will be explored next.

For the men in this study, the practice of hospitality was not a new phenomenon. They described the cultural significance of hospitality as originating in the past. Since then, the purpose of hospitality has changed significantly.

The practice was described as originating amongst past generations in India. During this time, serving guests in the family home had a specific purpose; to secure marital ties between two different families. The men explained how on these occasions, rich

celebratory food was offered, which reflected the host's wealth and status, and ultimately their suitability as a potential match for the prospective marriage. For previous generations, status was gained through the completion of these rituals and customs, which represented symbolic resources of the family and has also been found elsewhere (Mand, 2002). Other studies have also found a relationship between hospitality and marriage proposals within Indian communities, which have been described as a hierarchical relationship between the 'wife receivers' (bridegroom's family) and the 'wife givers' (bride's family) (Parry, 1979; Hershamn, 1981). For example, importance is placed on providing culturally appropriate hospitality to the barat (bridegroom's family), and is a widely recognised cultural norm within the wider Indian society (Waheed, 2009).

In this study, after migration occurred, there was a shift in the purpose of hospitality and what it meant in the UK. The men described how they believed it was no longer primarily associated with securing marital ties, but was used as a means to display a 'successful' status to others. In the contemporary setting, offering rich food and alcohol to guests on a regular basis became a way of showing wealth to others, and ultimately a family's success post-migration. It is this concept of hospitality that is now the cultural norm within the Indian Punjabi community.

These findings have shown that hospitality plays a pivotal role in the eating practices of Indian Punjabis, which has implications for their health as a group. For example, Indian Punjabis may not offer healthy food to guests due to the cultural importance attached to traditional 'risky' foods. This is particularly concerning if the cultural significance of hospitality is not only limited to times of celebration, but to all social

gatherings. This could mean that Indian Punjabis are regularly consuming 'risky' foods.

Food choice is a complex process, which involves a number of psychological, social, cultural and economic factors that shape food behaviours (Fischler, 1988; Meiselman et al., 1996; Rozin, 1980; Falk et al., 1996; Furst et al., 1996; Devine, 1998; Conors et al., 2001). The men in this study believed that eating practices are influenced by hospitality, which has been reproduced as a cultural norm over the course of generations to become an important socio-cultural practice. For Indian Punjabis, dietary choices are made in the absence of health concerns and are governed by traditional symbolism, which reduces the potential for change. It is in this way that the cultural practice of hospitality could be perceived as contributing to the prevalence of T2D within the Indian Punjabi community.

The following section will explore men's perceptions of the cultural and social norms that impact on drinking practices in the community.

6.1.2 Alcohol consumption: a male social practice

Much of what was found in this study about the men's drinking practices resonates with other findings on men's alcohol consumption in that they drank excessively in social settings (Karlsen et al., 1998) and drank to facilitate socialisation (Purser et al., 2001). It is reported in the literature that Indian men consume more alcohol compared to any other south Asian group (Ahuja et al., 2003; Singh et al., 2006).

Similarly, the men in this study identified themselves and other Indian Punjabi men as excessive drinkers compared to others.

The findings presented in this section explore the men's health beliefs related to alcohol consumption and drinking. The men perceived a relationship between alcohol consumption and masculine identity, which they believed to be one of the biggest influences on their drinking practices as a group.

The men in this study described drinking as a social activity, which is inextricably tied to masculine norms and cultural expectations. Furthermore, alcohol played an important role in the maintenance of the Indian Punjabi male identity. This was exemplified by the men's description of drinking as a 'manly activity' and how drinking was associated with 'being a man'. The significance of these cultural expectations is exemplified by the consequences associated with breaking away from these norms. Men who chose not to drink were outcast from other men and considered to be socially deviant.

The findings in this study reveal how Indian Punjabi men's drinking practices are heavily influenced by social constructions of masculinity. This is not an entirely new finding, as research has identified the relationship between masculinity and social behaviour, and the facilitating role of alcohol in the construction of the masculine identity (Connell, 1987; Courtenay, 2000, Visser et al., 2007).

However, the findings offer new insight into this area, especially in regards to how this group are engaged with their masculine and cultural identity through modern Bhangra music, and the implications this has on their alcohol consumption.

The men in this study described other men's excessive drinking as a legitimate activity as it is perceived to be a cultural component of the Indian male identity, and more specifically, the Jat male identity. Jat describes Indian Punjabis who derive from a particular caste. The Indian caste system is essentially a traditional social hierarchy, where caste is allocated from birth and describes occupational background.

A wide range of castes make up the Indian caste system, who are positioned at different social levels. For example, the Indian caste system also includes those from Hindi-Punjabi religious identities, including Chamars and Ravidassias, who are located lower on the social hierarchy than their Sikh counterparts (Jodhka, 2009). Only a few of the participants in this study were from a Hindu-Punjabi heritage, and whilst they did not discuss their own caste, they did identify with 'Jat maleness' and recognised it to be a common caste attribute.

Traditionally, Jat people come from an agricultural background and are positioned high in the caste hierarchy. In this study, Jat men were stereotypically defined as tough, strong and risk takers. Jat maleness was also defined by the ability to drink alcohol. These characteristics also mirror western hegemonic descriptions of masculinity (Connell, 1987, 1995).

Cultural norms about Jat masculinity were described by the men as being reproduced in the Indian Punjabi community via Bhangra music. Bhangra music was also described as promoting Jat masculinity specifically through provocative lyrics which endorse Jats as superior to others. Bhangra is a genre of popular music

associated with Punjabi culture, which developed in the 1980s in Britain by first- and second-generation Indian Punjabi migrants (Dudrah, 2002).

The findings presented in this study highlight the lyrical content of Bhangra music, which play a role in the promotion of the Jat caste identity. It is in this way that Bhangra music can be considered as a cultural tool in which Indian Punjabis use to reaffirm their own identity.

These findings demonstrate the interplay between Indian Punjabi male identity and modern Bhangra music, which has become a space for identity construction for the diasporic Indian Punjabi community. These findings have been supported in other work (Sandhu, 2009), and mostly by Dudrah (2002) who explored the ways in which Bhangra music has become a tool for the Sikh diasporic community to negotiate their identities (Dudrah, 2002). However, the impact this identity construction has had on health behaviours has been under-theorised. The findings from this study demonstrate how the male Indian Punjabi community are exposed to cultural messages about identity politics which influence health behaviours, and specifically alcohol consumption.

There are different ways of being masculine (Connell, 1995; Edley and Wetherell, 1999; Frosh et al., 2002). For Indian Punjabi men, drinking alcohol is one way of 'doing' masculinity. The findings presented here reveal the extent to which Indian Punjabi men's drinking practices are heavily influenced by social constructions of identity and masculinity. In other words, drinking is an important cultural component of the Indian male's masculine identity, and the Jat male caste identity.

The way in which drinking is linked to masculine identity could have important health implications for Indian Punjabi men. It could be suggested that Indian Punjabi men are under pressure to conform to cultural expectations of masculinity, and as a result they are jeopardising their health.

The following section of this chapter will now address the second objective of the study.

- To explore how the risk of T2D is perceived amongst Indian Punjabi men

As discussed in Chapter Five, the concept of 'risk' was applied during the analysis of the findings to clarify how the participants spoke about the perceived threat of T2D.

Whilst many of the men in this study did not always use the word 'risk', risk was referred to in an indirect way in their descriptions of the threat of T2D.

The men spoke about the risk of T2D in two ways: the personal risk of T2D (personal risk perception), and the risk of T2D affecting others in the community (collective risk perception). The following section will explore each of these in order.

6.1.3 Personal risk perception

The way in which the men perceived their personal risk of T2D differed between the first and second generation. The first-generation men were less inclined to talk about their risk of T2D or about their health in general. Instead, they spoke about the community's risk of T2D. They appeared to be more at ease talking about health

risks collectively, as opposed to individually. Their reluctance to discuss their health risks could be explained by their upbringing in India. India is a traditional collectivist society, which has been identified by some as the reason behind an individual's reduced likelihood of independent behaviour (Macaden and Clarke, 2006). This can be extended to explain how Indians are less likely to consider their personal health, and more inclined to reflect on the health of society as a whole. This explanation also frames the men's understanding of risk within their socio-cultural origins, reinforcing the notion that understandings of risk differ within wider social and cultural contexts. When the first-generation men did speak about health risks, they did not recognise the link between T2D and other chronic conditions such as hypertension, which were perceived as separate and 'less risky' than T2D. This finding suggests that this group may have knowledge gaps about the relationship of health risks, which has also been found in other south Asian communities (Kandula et al., 2010). In addition, the first-generation men were less likely to seek help and health advice from HCPs. On the whole, this group were disengaged with their risk of T2D, which could be explained by the fact that they did not perceive themselves at risk of T2D in the first instance.

In contrast, the second-generation men were knowledgeable about the modifiable risk factors associated with T2D, and took ownership of their risk. For instance, some modified their traditional and western diets by reducing foods they perceived as 'risky' to their health.

Having friends and family with T2D was the only common factor that influenced the men's sense of personal risk across both groups. Witnessing others suffer from T2D and other chronic conditions increased the men's sense of personal vulnerability, which only prompted behaviour change amongst the second-generation men. The

reasons behind why this occurred were not evident in the findings, but it could be suggested that having a family history of T2D may have increased the men's personal sense of risk due to the recognition of a familial or genetic link, which has been found elsewhere (Montgomery et al., 2003). For both groups of men, their sense of personal vulnerability was also affected by their perception of ageing. For example, health risks only become a concern later in life, and youth was characterised as a 'risk free' time. This finding is particularly important as it suggests that the men's perceptions of health risks become normalised as a part of ageing and later life. This could have profound repercussions on the development of effective preventative strategies for these men. In addition, this finding has implications for clinical practice and the current emphasis for early detection of T2D amongst high-risk groups such as south Asians under the age of forty (NSF, 2001).

The majority of research conducted on people's risk perception of T2D tends to focus on those who are already diagnosed with the condition (Macaden and Clarke, 2006; 2010). The findings in this study focus on Indian Punjabi men's risk perception of T2D, who fall under the category of 'at risk'. The findings reveal that the first-generation men are in denial about their risk of T2D. In addition, they have knowledge gaps about the condition compared to the second generation, who appear to be taking ownership of their risk by modifying some of their lifestyle practices. These findings have implications when attempting to understand how Indian Punjabi men identify with their personal risk of T2D, which clearly differs between two generations. These findings suggest that the first-generation men could be less likely to be receptive to personal-risk awareness strategies compared to their younger counterparts.

The literature exploring the predictors of perceived risk of T2D is far less well developed amongst Indian Punjabi men who live in the UK. These findings contribute to this area by highlighting that family history increases the sense of personal vulnerability amongst all the men, and influences behaviour change amongst the second generation. In addition, the first-generation men appear to be less aware of their personal risk of T2D compared to the younger generation.

The following section focuses on how the participants spoke about the risk of T2D in relation to other people in the community.

6.1.4 Collective risk perception

As previously mentioned, only the first-generation men spoke about other people's risk of T2D rather than their own risk. It could be argued that this group may have a perceived sense of invulnerability from T2D, which would explain their lack of concern for the risk factors on their own health. This suggests that their perception of their own risk of T2D is considerably low. This finding could have important implications for HCPs who might face difficulties when raising the issue of risk with older-generation patients. It also raises concerns in the effectiveness of educational strategies designed at targeting people who identify themselves as 'at risk', which might not be as effective for people who do not consider themselves as at risk.

This section explores the four factors the participants identified as having an influence on the Indian Punjabi community's risk of T2D. These included dietary

practices, educational attainment, shared attributes and time and place. These will be explored next.

6.1.4.1 Dietary practices

The men in this study identified specific foods within the Indian Punjabi diet that were considered to be 'risky' to health, and contributed to the community's risk of T2D. Fat, ghee and butter were considered to be unhealthy food ingredients and a threat to health. These 'risky' foodstuffs were described as being regularly consumed in the Indian Punjabi diet, and deeply embedded within the cooking and eating practices of the community. The men's perception of their traditional diet as unhealthy has been found in other work conducted with migrants (Fagerli et al., 2005; Netto et al., 2007; Greenhalgh et al., 1998; Chowdhury et al., 2000).

The findings presented in this study have implications for the improvement of dietary advice targeting the Indian Punjabi community who are at high risk of eating traditional 'risky' foods. Dietary advice is an important component of T2D care, however full adherence to dietary regimes by patients with T2D can prove difficult to achieve (Lawton et al., 2008). The findings in this study demonstrate that Indian Punjabis may face barriers adhering to dietary advice due to their preferences which current advice may not address (Connor et al., 2003). The findings suggest that dietary advice for this group should encompass and take into account traditional food ingredients and ways of cooking to increase the relevance of advice. Strategies promoting health eating for this group should also acknowledge the food beliefs this

group may have about specific ingredients. For example, within the Gujarati community ghee is perceived to have strengthening properties (Khajuria and Thomas, 1992). Therefore, dietary advice should be tailored to inform patients that traditional ingredients which are high in fat are only acceptable as part of a healthy balanced diet.

In order for dietary advice to be effective for the Indian Punjabi community, health care professionals need to tailor their approach to be inclusive of their specific dietary practices in order to increase adherence.

The next section will explore the role of formal education on the health of the Indian Punjabi community.

6.1.4.2 Education and informal learning

The Indian Punjabi community's lack of formal education was another factor that influenced their health outcomes, and increased their risk of T2D according to the men in this study. Older members of the community were described as uneducated, due to limited access to formal education during their time living in the UK. Their lack of education was considered to be one of the reasons why they have significant knowledge gaps about health and T2D risk. This was due to the fact that their lack of education reduced their opportunity to learn about risk, preventative action or treatment. However, the men in this study identified informal learning as a potential method in teaching elders about health risk and T2D. The men spoke retrospectively about the benefits of learning about health risks via friends and family. Adult children

were identified as being the best communicators of health information as they were perceived to be 'more knowledgeable' about health and therefore suitable to inform elder relatives about health risks.

The evidence on how family members, and more specifically adult children, can play a role in promoting health to older family members is a neglected area (Sindal, 1997).

The findings presented in this study suggest that the adult children of older Indian Punjabi parents may be successful in promoting health messages about T2D. In bridging the gap between their elders and healthcare professionals, adult children could act as advocates in the exchange of health information. This approach would have particular relevancy for older Indian Punjabi men who seem to be reluctant to seek advice from HCPs, and appear to be disengaged with health-care services. These findings also have the potential to inform practice and HCPs engagement in T2D risk communication with older Indian Punjabi patients. For example, the development of future interventions could be inclusive of educating family members of older Indian Punjabi patients to improve the health outcomes of this group.

The next section explores some of the shared characteristics of Indian Punjabis that the men identified as contributing to their increased risk of T2D.

6.1.4.3 Attributes of the community

The men in this study spoke about some of the common attributes Indian Punjabis have, which they considered to be barriers to good health practices. These were largely stereotypical descriptions about the collective's dismissive attitudes towards

health. For example, the men described Indian Punjabis as a group who are uninterested in physical activity, and ruled by their preference for taste over health concerns. Indian Punjabis were also described as being overly prone to stress, which increased their likelihood of developing health problems.

Alongside these traits, the men in this study described Indian Punjabi males as being governed by their masculine identity, which was considered to be the reason for some of their unhealthy lifestyle practices. For example, Indian Punjabi men were described as ascribing to patriarchal masculine norms such as strength and pride, which negatively influenced how they managed their health risks. Masculinity played a major role in Indian Punjabi men's reluctance to engage with HCPs, as being seen as ill or in poor health jeopardises masculinity. This has also been found amongst other groups of men (Addis and Mahalik, 2003). For example, the way in which illness or physical impairment is construed as emasculating amongst some groups of men can have negative consequences for men's identities which can shift to become feminised or marginalised (Gershick and Miller, 1995). This has also been found amongst other Sikh men (Harman et al., 2008).

The findings in this study demonstrate that for Indian Punjabi men, masculinity is an important determinant of health. This is not a new finding, as gender and masculinity are important socio-cultural factors which influence health and health related behaviours (Courtenay, 2005), and there is evidence of the complex relationship between identities, gender roles and health and illness practices (Connell, 1995; Doyal, 2000; Watson, 2000; O'Brien et al., 2005; Oliffe, 2009; Robertson, 2007; King et al., 2006).

The men in this study acknowledge that by 'being masculine', Indian Punjabi men are jeopardising their health in order to comply with masculine ideals. The tendency for Indian Punjabi men to engage in high risk practices such as excessive alcohol consumption and avoiding healthcare advice can be interpreted as practices of masculinity, which contribute to the poor health outcomes of these men.

These findings add to the current literature to reveal how masculine norms are dominant within south Asian culture, and remain dominant despite the effects of shifting contexts due to migration (Connell, 1995; Seidler, 2006; Pease, 2009). In addition, these findings reveal the extent to which both immigrant and UK born men's health practices take place within the context of masculinity.

However, it is important to consider the existence of various masculinities (hegemonic, complicit, and subordinate) in which different groups of men belong to. Evans et al. (2011) discuss the existence of multiple masculinities which reflect the social diversity of men associated with age, ethnicity and class (Evans et al., 2011). They argue that the ways in which health is determined within these different groups are not generalisable to all men, and therefore they do not experience health in the same way (Evans et al., 2011). The findings presented in this study demonstrate the need for further theory development to consider Indian Punjabi men's health and illness practices within a larger social context in which masculinity is defined and produced.

The findings in this study have implications for the design of health promotion targeting Indian Punjabi men as it could be argued that their construction of masculinity and its relationship with health practices could be conceptualised as a

health risk. Therefore, health-care services designed for this population should be designed to adopt a holistic approach to include masculinity as an important factor in the health-risk management for this population.

The final section explores how both first- and second-generation men spoke about the relationship between time and place and health risks.

6.1.4.4 Health risks and place

The findings revealed the men's perceptions of place and its effects on health as both groups of men contextualised health risk as occurring within a specific place. The first-generation men spoke about the role of migration and change of place on the community's poor health. Similarly, the second generation identified university as a place in which their own health was most at risk.

The first-generation men spoke about adjusting to life in the UK post-migration, which was a place where the older generation became exposed to health risks. They described the challenges that came with described the drinking behaviours of migrants as excessive during this time, as they used alcohol to combat loneliness and facilitate socialisation with other migrants in a new environment. The significance of place also played a role in the transformation of health practices from 'healthy and facilitating' to 'risky' during the men's migration from India to the UK. For example, the men in this study spoke about the consumption of a high-calorie diet, which was facilitative to strenuous physical work and agricultural life in India. It was only when

the place changed that these habits became substantial threats to health. The men concluded that many of these lifestyle choices have remained the same today, and have become the foundations on which risky health behaviours have developed.

Place was also significant for the second-generation men. They spoke about their own health being most at risk during their time spent during further education, namely university. The men described this particular time of their life where drinking alcohol was a social priority, and health lifestyle practices were abandoned in the pursuit of fun and enjoyment. These findings appear to show that the second-generation men are replicating similar drinking habits to their elders during their time at university, and for similar purposes: to be sociable with others.

The findings demonstrate the extent to which particular places are perceived to influence health and health related behaviours within the Indian Punjabi community. The causal relationship between characteristics of place and individual health outcomes has been explored elsewhere (Airey, 2003; Frohlich et al., 2001; Popay et al., 2003). However, there has been minimal exploration into the effect of 'place' on health amongst Indian Punjabi migrant communities (Macintyre et al., 2002). This is especially concerning since the process of migration has been described as a disruptive experience for most migrants (Williams and Hunt, 1997; Noh and Avison, 1996; Lambert and Taylor, 1990). It appears that there is currently a lack of conceptualisation of the effect of place on health outcomes for this group, as the findings presented here demonstrate the extent to which context and environment matters for individual health (Macintyre et al., 2002).

These findings have the potential to inform public health interventions about the importance of place as a distinguished factor which affects health outcomes for this group.

6.1.5 Summary

The findings presented in this study highlight the various factors, acting at both individual and community level, which influence health related behaviours of Indian Punjabi men. The findings also reveal the relationship between; limited knowledge of T2D, perceived risk of T2D, ingrained health beliefs, lifestyle changes following migration and strong adherence to cultural norms. The findings highlight the extent to which Indian Punjabi men's eating and drinking practices are inextricably tied to cultural norms, which act as strong barriers to behaviour change within this community. The findings also demonstrate how these practices are subject to change depending on age, gender and place.

By examining Indian Punjabi men's health beliefs and practices and contextually situating them within their cultural milieu, these findings have the potential to inform health promotion interventions aimed at this group (Netto et al, 2010). Currently, the evidence base for developing effective health promotion interventions for ethnic minorities is still in its infancy (Netto et al, 2010). In addition, there is a lack of evidence-based methods to assist researchers and HCPs on how to best adapt health promotion interventions (Liu et al, 2012).

Whilst many terms are used to describe the adaptation of health promotion interventions for ethnic minority populations (e.g. culturally sensitive/ culturally tailored) (Netto et al, 2010), there is limited understanding of the specific factors which need to be considered in the creation of adapted interventions (Bhopal, 2006). Bhopal (2006) discusses the importance of adapting of current interventions whilst the development of an evidence base for minority ethnic health initiatives continues (Bhopal, 2006). However, it is essential that the adaption of existing interventions are defined by a set of processes which enhance its appropriateness. For example, interventions should address deep rooted influences on health behaviours within 'at risk' groups (Resnicow et al, 1999; Greenhalgh et al, 1998). Resnicow (1999) explored the differences between surface and deep structured interventions. Resnicow argued that while surface level interventions may increase the receptivity of health messages, it is deep structured interventions that will influence behaviour change (Resnicow, 1999). Similarly, Greenhalgh et al. (1998) highlight the importance of designing education interventions to be inclusive of user perspectives and beliefs. In addition, rather than correcting knowledge and behaviour, health promotion interventions should build on pre-existing beliefs and behaviours to promote healthier lifestyles (Greenhalgh et al, 1998).

The growing interest in this area has centred on the fact that evidence on health promotion has largely focused on white European origin groups, and neglected ethnic minority populations (Liu et al, 2012). In addition, synthesis into current evidence has found minimal evidence into information about the effectiveness of health promotion intervention in ethnic minority populations (Liu et al, 2012).

The findings from this study has identified the 'deep-rooted' aspects of Indian Punjabi culture which are likely to influence health related behaviours for the Indian Punjabi community, and reveal the extent to which this group affiliate with cultural norms. It is in this way the findings highlight the need for a more nuanced understanding of the relationship between health behaviours and factors which influence behaviours within ethnic minority sub-group populations, as exploring culture alone may not be enough (Chiang, 2005). Without highlighting these factors, efforts to reduce T2D in this and other similar 'at risk' groups are unlikely to be successful.

The following section will examine the original contributions of this study, and includes the contributions this study makes to the existing subject area, practice and policy and why they are important.

6.2 Contributions to knowledge

This study is the first time health beliefs and risk perceptions related to T2D have been explored across two generations of Indian Punjabi men in the UK. As a result, this study makes a number of contributions to knowledge in the area of south Asian health research. In the following section, contributions to knowledge in relation to the existing literature will be discussed and will be followed by a summary of implications for policy, practice and further research.

6.2.1 Contributions to existing knowledge

The findings from this study make an original contribution to current knowledge about south Asians' health beliefs and perceptions of risk of T2D by focusing on a subgroup who are currently under-represented in the literature: Indian Punjabi men.

As previously discussed in Chapter Three, south Asian health beliefs and practices are influenced by social and cultural norms and values. Religion, social expectations and modesty are some of the constructs which impact on how some south Asians understand T2D causation, and how they engage in health practices. However, these norms and values are not experienced universally across all south Asians. Significant heterogeneities exist between the subgroups in relation to religious influences, cultural and structural barriers and identity. Despite this, research continues to describe south Asians as a homogenous population. As a result, the experiences of Indian Punjabi men have been excluded from the research gaze. This study addresses this gap by exploring Indian Punjabi men's health beliefs and risk perceptions of T2D.

The findings revealed the cultural significance of hospitality and drinking. These were important socio-cultural practices within the Indian Punjabi community, and affected how they ate 'risky' foods and excessively drank alcohol in social settings.

The findings presented in this study support the existing evidence on hospitality within the south Asian community, which has found it to be an influence on social eating practices and identity construction (Murcott, 1982; Bush et al., 1998; Bradby, 2002; Grace et al., 2008). However, the findings in this study contribute to this area by revealing the socio-historical origins of hospitality. The findings in this study

situate the beginnings of hospitality in ancestral India for the purposes of creating marital ties. Previous explorations into hospitality tend to overlook the roots of the practice, and how they have come to be for different south Asian groups. In addition, the findings also reveal the new function of hospitality in modern everyday life: a mechanism to create a 'successful' identity.

These findings are significant in recognising that hospitality is deeply ingrained and a cultural cornerstone of Punjabi social life. Food consumption takes place within the context of obligation, therefore little concern is attached to 'risky' foods. It is the way in which hospitality governs the consumption of 'risky' foods in social settings that means it has important health implications for Indian Punjabi people.

The findings in this study also make a contribution to the evidence on Indian Punjabi men's drinking practices. Their excessive social drinking practices, and the relationship between alcohol and male identity construction has been found amongst other groups of men (Connell, 1987; Karlsen et al., 1998; Courtenay, 2000; Purser et al., 2001; Visser et al., 2007). However, the findings in this study contribute to knowledge about Indian Punjabi men's drinking practices by revealing the role of caste identity.

The men's descriptions of the Jat male identity, as characterised by Indian social hierarchy, appear to contribute to Indian Punjabi men's excessive drinking in the UK. In India, Jat men conducted physical work as farmers, and alcohol facilitated laborious work. In addition, drinking contributed to what it meant to be a Jat man. In the UK, the role of Jats has changed due to the absence of agricultural work, however the meanings ascribed to the male Jat has remained the same and is

reproduced by alcohol use. In addition, younger generations are being exposed to the cultural norms surrounding Jat 'maleness' through popular Punjabi culture and Bhangra music.

The men's description of the 'Jat' caste signifies that they identify with a transnational identity in the UK. This cultural hybridity suggests that Indian Punjabi men are rearticulating their masculinity in the UK through the consumption of alcohol.

It could be suggested that this occurred after migration, which challenged men's identity due to a loss in shared land and commonalities. Therefore, drinking became a way of preserving cultural heritage and masculine norms. These findings reveal the extent to which drinking is contextualised within historical and social history in the Indian Punjabi community. Therefore, this suggests that as a practice, drinking is deeply embedded within the lives of Indian Punjabi men, which makes it difficult to change or modify. It is in this way that alcohol is a serious health implication for this group.

The findings presented in this study make a significant contribution to the area of risk perception, and reveal how Indian Punjabi men perceive their risk of T2D. The findings address the gap in evidence by highlighting the generational difference in how the men perceived risk of T2D in either individual or collective terms.

There has long been an interest in the exploration of people's perception of diabetes causation, and the ways they differ from biomedical paradigms (Blaxter, 1983). On the whole, biomedical information plays a small role in people's perceptions, as other factors have more influence, such as personal and social histories (Blaxter, 1983). However, studies exploring causation accounts of T2D tend to focus on those who

already have the condition (Schoenberg et al., 1998; Hunt et al., 1998; Lawton et al., 2008). Little research has focused on the risk perceptions of those 'at risk' but not yet diagnosed with T2D. Studies exploring the perceptions of those 'at risk' has potentially important implications for practice, especially for the enhancement of primary prevention strategies. These findings address this gap in the literature by revealing Indian Punjabi men's risk perceptions of T2D across two generations.

In terms of their personal risk of T2D, only the second generation were aware of the modifiable risk factors associated with T2D. In addition, they also took action to reduce their risk by modifying aspects of their diet that they perceived as 'risky' to health. In comparison, the first generation were more wary of their individual risk of T2D than the second generation.

The first-generation men were less engaged with their individual risk of T2D. This was demonstrated by their unwillingness to seek professional help, and the knowledge gaps they had about the relationship between health risks. Overall, the first generation did not consider their personal risk of T2D, which suggests that they are a group who do not perceive themselves as at risk in the first place.

Having family and friends with T2D was the only influencing factor that increased both groups of men's perception of personal risk of T2D. It appeared that the witnessing of others with the condition increased the men's own sense of personal vulnerability, and prompted behaviour change amongst some members of the second generation. Growing older was perceived by both groups of men as being synonymous with the inevitability of illness and poor health whereas youth was

considered to be a risk-free time. This finding reveals how the perception of ageing has a role in the understanding of health outcomes.

The first generation were more invested in the community's risk of T2D, and perceived the risk of T2D collectively. The men's judgements about the community's risks were grounded in the social and cultural context of everyday life. For example, they identified a number of micro and macro contextual factors that played a role in the Indian community's increased risk of T2D, which included dietary practices, education, personal attributes and place. Despite identifying numerous reasons for the high risk Indian Punjabis in the community face, the men did not perceive themselves as part of the 'other'.

These findings contribute to the existing research on lay accounts of causation by focusing on the perceptions of an 'at risk' group. These findings make an important contribution to knowledge as they reveal the risk perception of those at risk of T2D and highlight that perceptions of risk are not the same across two generations of Indian Punjabi men. These findings demonstrate a difference in how the first and second generation perceive their risk of T2D, in that the first generation are less likely to adhere to information about personal risk of T2D compared to the second generation.

These findings support evidence that there are noticeable differences between lay explanatory models and biomedical understanding of T2D (Cohen et al., 1994). The first generation's perception of risk and theories of T2D risk are largely attributed to their personal experiences of everyday life. Their lay belief system collates different

aspects of life to explain the cause of disease, which highlights that their perception takes place within a cultural setting (Bury, 2001).

The way in which the first-generation men externalised the risk of T2D can be considered within the context of Dumont's (1970) discussion of the influence of originating from a traditionally holistic culture. Dumont put forward that some societies, including India, are defined by a holistic culture in which individuals are embedded within larger social structures such as kinship and family, which leads to individuals developing a 'socio-centric concept of self' (Dumont, 1970). From this perspective, the body is not a singular entity but influenced by social relations. In the context of the findings presented in this study, this theory provides an explanation as to why the first generation might be inclined to look to external causes when explaining the risk of T2D due to their cultural background and heritage.

These findings are in accordance with the cultural theory of risk, especially in relation to how, for first-generation men, empirical perceptions of risk of T2D are socially constructed, and shaped by the socio-cultural contexts in which they are situated (Bradbury, 1989).

However, the first-generation men's perception of risk fails to fit into Douglas's (1978) description of the grid-group typology. Instead, the men appear to be outside of the group, looking in on society and making judgements about others' risk and health outcomes. Whilst the findings do allude to the fact that risk perceptions are influenced by the context in which it is made, cultural theory suggests that the men's perception can be generalisable to all members of the Indian Punjabi community who may view risk in a similar way.

The findings about risk perception reinforce the notion that risk perceptions do not occur within a social vacuum, and to fully comprehend risk perceptions cannot be done without a consideration of the wider social and cultural contexts from which they originate.

6.2.3 Implications for practice

The findings of this study have implications for improvements to T2D service delivery for the Indian Punjabi community, and for future interventions aimed at this group.

Improvements in the delivery of lifestyle advice and risk information given by HCPs need to be culturally tailored for this group to help facilitate adherence to information, which will be explored in detail next.

These findings have implications for how HCPs deliver risk information to the Indian Punjabi community, and especially how they should tailor their approach depending on whether the patient is first or second generation. This study has shown that members of the first generation are less likely to seek professional health advice, and are generally less engaged with health services compared to the second generation. This suggests that interventions and services delivered within traditional medical settings may not be appropriate in targeting this particular population. If HCPs are to be successful in raising awareness of T2D amongst the older population, their approach should be more specifically tailored towards their needs. This could be achieved through a collaboration between HCPs and leaders in the local communities to help facilitate the delivery of interventions and services within community settings such as the Gurdwara.

Risk information targeting the family would be beneficial in raising risk awareness in both first- and second-generation Indian Punjabis. This could be achieved through the development of written literature which includes community members' experiences of T2D to increase risk awareness amongst those deemed 'at risk'.

Health-education services need to focus on improving the knowledge base of the older generation, and should be adapted to address some of the common misconceptions this group have about the relationship between risk factors and chronic disease. Most importantly, advice about risk management should be orientated to the patients' motivations. Currently, strategies aimed at prevention and early detection of T2D, such as the NHS Health Check Programme, are structured around individual patient goals (NHS Health Check Programme, 2009). This approach might not necessarily be effective in raising awareness with the elders as they tend to think about risks collectively. Therefore, developing a strategy that is inclusive of the collectivist mind-set would be beneficial in engaging older generations into thinking about their risk of T2D.

When it comes to designing health-care education aimed at the older generation, this study reveals that the traditional method may not be useful in teaching this group about their health risks. Education interventions should be adapted to include informal learning strategies, with the inclusion of family members who can relay health messages to the elders.

These findings also have important implications for how HCPs give lifestyle advice about food and diet for Indian Punjabis. Firstly, HCPs should be aware of the cultural norm of hospitality, and work to include it as an influencing factor on eating practices

in their delivery of lifestyle advice. This could include the promotion of lower-fat cooking alternatives to be used in traditional diets, as opposed to the modification of the whole diet, which could reduce the likelihood of acceptability amongst this group.

The findings have shown that this group place importance on group norms and values, therefore HCPs should tailor their approach to include the wider community. The creation of community initiatives that address dietary issues and the risks associated with T2D could enhance people's acceptance of changing cooking habits. Changes could also be made to the way in which food education and advice is delivered for this group. The traditional approach, which focuses on changing individual health goals, may not be appropriate for this group who see themselves as having specific roles and identities to fulfil within the family and in the community. Since hospitality primarily takes place within the home, advice could be aimed at families to help the promotion of the discussion of healthier food options within the home.

These findings also have direct implications for informing HCPs of the increased alcohol consumption amongst Indian Punjabi men. For example, GPs may be unaware of how high the risk is of Indian Punjabi men drinking, and wrongly assume that all south Asian men abstain from alcohol in the same way the Muslim population do. One of the biggest impacts of this study is to highlight to the medical community that being an Indian Punjabi male may lend itself to being a 'risk factor' for excessive drinking. This is particularly important as it has been documented elsewhere that confusion exists around the drinking practices of Indians, which has occurred due to the stereotypical view that Indian men do not drink as it conflicts with traditional Sikh teachings (Sandhu, 2009).

The findings from this study highlight that caution should be applied when considering the religious identity of Sikhs and health behaviours. For example, whilst the men in this study did not adhere to traditional Sikh teachings such as abstinence, they still identified themselves as Sikhs. This suggests that some members of modern Sikhism are dynamic in how they are choosing which religious teachings to follow and dismiss. It could be argued that this has resulted in a hybridity of the religion, due to how it is being diversely practised amongst its followers. This finding has the potential to inform HCPs about the religious identity of Sikhs, which may or may not indicate abstinence from alcohol. Thus, HCPs should be encouraged to ascertain which nationality south Asian men originate from, in order to become more specific in their alcohol questioning.

Interventions aimed at reducing Indian Punjabi men's alcohol consumption should also be inclusive of the influencing factors which encourage drinking within the community. For example, this study revealed how popular Bhangra music played a role in the promotion of alcohol consumption through the reproduction of cultural messages about Indian maleness and masculinity. HCPs delivering education to this group should be mindful of Bhangra music as a potential barrier to changing attitudes about drinking practices amongst Indian Punjabi men.

In addition, advice about alcohol should also be aimed at the second generation who appear to be consuming alcohol in the same way as their elders. This is particularly important because other evidence has shown that the drinking behaviours established during youth can be predictors of drinking behaviours in later life (Merline et al., 2004; Jefferis et al, 2005).

Whilst lifestyle interventions aimed at Indian Punjabis should primarily focus on addressing their main health risks, they should also be tailored to reduce advice on less significant health risks such as smoking. The findings from this study revealed the cultural taboos attached to smoking within the Indian Punjabi community, which make it less of a risk factor compared to drinking. One of the advantages of tailoring lifestyle interventions towards the needs of the population in this way is that it may influence uptake in the community by being more culturally appropriate, and therefore more relevant.

In summary, these implications for practice highlight the importance of HCPs recognising that their advice might lack acceptability, which might reduce adherence amongst Indian Punjabis. These findings reinforce the notion that advice about lifestyle choices and risk needs to be sensitive to the groups' beliefs and attitudes. Currently, T2D management strategies are based on models of individualism (Barlow et al., 2002), which may not be appropriate for the Indian Punjabi community. Whilst the health beliefs and practices of this group may not be the same amongst other south Asian groups, highlighting Indian Punjabi men's health beliefs and risk perceptions is important for their engagement in preventative behaviour and appropriate risk management.

6.2.4 Policy

The findings of this study have important implications for policy initiatives related to the risk assessment of T2D for people at high risk.

Current policy initiatives are focused on the prevention and early detection of T2D amongst the general population and high-risks groups, including south Asians (NICE, 2011). Recommendations for providers of public-health services focus on identifying people at risk of developing T2D and providing them with an evidence-based, lifestyle-change programme to prevent or delay the onset of T2D (NICE, 2011). This includes GPs and other HCPs offering risk assessment to patients by explaining why people can be at risk of developing T2D even though they feel healthy.

The findings in this study demonstrate that careful consideration needs to be given to how risk information is delivered to at-risk groups, such as Indian Punjabis, especially the older generation, who do not consider themselves as at risk of T2D. Policy initiatives focused on the delivery of risk information and assessments need to be modified to overcome this potential barrier, and target groups who are high risk for non-accordance to risk information. This could be done through the adaptation of information delivery, which moves away from a focus on individualised patient goals, but instead on risks in the wider community.

The findings of this study also suggest that Indian Punjabis are less than likely to modify lifestyle practices that are deeply embedded in cultural and social norms and values. This has implications for the providers of intensive lifestyle-change programmes, which may lack acceptability, especially on dietary modifications such as decreasing fat intake (NICE, 2011).

If policy is to effectively reach south Asians, it will need to move away from the 'one size fits all' approach and incorporate the vast cultural differences into its care strategies to include different groups of the south Asian population.

Table 18. Summary of recommendations for policy

- | |
|--|
| <ul style="list-style-type: none">• Consider how the perception of risk differs between groups• Improve risk communication by including community risk factors• Identify that south Asians are heterogeneous and require tailored advice based on their cultural differences |
|--|

6.3 Methodological considerations

As discussed in Chapter Four, a number of strategies have been employed to ensure rigour in this research study. This included: keeping an audit trail which documented the methods of data collection and analysis; and the completion of a review by colleagues who examined the data analysis and coding framework. The reliability of this research was also enhanced by the inclusion of extracts of the raw data to make the interpretative process explicit (Mays and Pope, 1995).

It is important to attend to the issue of generalisability when discussing rigour in qualitative research. Under the quantitative framework, generalisability refers to the question how results of a study can be readily applied to other populations and settings (Campbell and Stanley, 1963). In qualitative research, generalisability is rejected, as Denzin (1983) argues:

“The interpretivist rejects generalisation as a goal and never aims to draw randomly selected samples of human experience. For the interpretivist every instance of social interaction, if thickly described, represents a slice from the life world that is the proper subject matter for interpretive inquiry” (Denzin, 1983: 133 in Morgan 1983)

Instead, emphasis is placed on the production of a coherent description of the phenomenon that based on the details of the study (Schofield, 2002). It is in this way that the findings of this study may not be generalisable to all south Asians, but are useful in revealing new empirical knowledge about the health behaviours and risk perceptions within one underrepresented group.

6.4 Limitations

This study explored the factors influencing Indian Punjabi men's health beliefs and risk perceptions of T2D. However, some limitations can be identified within this research study.

Firstly, it is important to address the implications of the use of snowball sampling as the recruitment method in this study. One of the main disadvantages of using snowball sampling is that it is a non-probability method (Bailey, 1994), and therefore could not guarantee the recruitment of a random sample. Participants in this study were not recruited by chance, which means that any conclusions drawn from this sample might be biased. One example of bias appears in how the sample in this study appears to be an over-representation of men who share similar demographic characteristics. For example, many of the men came from high socio-economic backgrounds and were educated, which might have influenced how they understood the values and risks of research participation. In addition, the participants derived from a common cultural background as many of them shared the same religious and caste identity. Therefore it could be assumed that the men may have had similar life experiences as each other. This may have limited the potential richness of the data

as it may have only been representative of one group who shared the same viewpoints, and not of the wider Indian Punjabi population. However, this sample does not claim to be representative of the whole Indian Punjabi community. Instead, the sample aims to reflect the experiences of one seldom-heard group who exist alongside a variety of other sub-groups, such as Punjabi Chamars (Jodhka, 2009), and represent one part of the rich tapestry that is the wider Punjabi diaspora who live in the UK.

The recruitment of men from similar backgrounds can be partly explained by how they were recruited by the key informant, who had close social connections to the participants. This suggests that a small group of the population were sampled as opposed to a larger representation. However, the snowball sampling method was not selected in this study to gain representativeness, but to access a group in a community which were difficult to locate through other means. In addition, this sampling method was appropriate as this study was not concerned with gaining wider inferences across a whole population, but instead gaining a deeper insight into understanding health beliefs and risk perceptions across two generations of Indian Punjabi men.

Secondly, the positioning of the researcher in this study can be perceived to have implications for the findings of this study. For example, the researcher had a dominant role in the whole research process, from research design to data collection and analysis. The researcher was not detached as an impartial observer, but had an active role and was deeply embedded in the process of the research. The importance of the role of reflexivity acknowledges this relationship, so that personal bias and beliefs can be identified (Finlay, 2002). The reflexive experiences of the researcher

are described in Chapter Four, in an effort to recognise and make visible any personal values and biases. However, it is possible that the researcher influenced some of the outcomes, such as the interview process. For example, the researcher's appearance, mannerisms and body language may have influenced how much the participants disclosed. Although these influences were identified (see Chapter Four), it is possible to suggest that another researcher might have conducted the interviews differently, which might have resulted in slightly different results.

6.5 Recommendations for further research

This study has begun to fill in the current knowledge gap which exists in relation to Indian Punjabi men's health beliefs and perceptions of risk, however there are areas which remain unexplored which could be developed in future research. What follows is the identification of broad areas for exploration in light of the main findings of this study. Other possible areas for exploration are presented in Table 19.

One of the findings in this study has identified hospitality as an important social practice, which has influenced how Indian Punjabi men consume food and alcohol in social settings. Further research could be conducted to explore the role of everyday food and how 'ordinary' meals are created within the home. For example, research could begin to explore Indian Punjabi women's role in food preparation in the home and their influence on eating behaviours. This kind of research could also reveal potential areas where risk is managed on a day-to-day basis through food preparation and cooking. Research focused on the home-making experiences of

Indian Punjabi women could begin to explore how food choices are made, which could have a major impact on changing long-term T2D outcomes for this group.

This study also found that alcohol related behaviours are steeped in cultural expectations and norms associated with masculinity. Further research could explore these trends amongst third generation male and female young adults to explore if their alcohol consumption is influenced in a similar way.

In terms of risk perception, further work could be conducted on understanding first-generation Indian Punjabi women's risk perceptions to draw out any similarities and differences with their male counterparts. The findings of this kind of study would provide a wider understanding of how risk of T2D is perceived across the population, and if gender differences exist:

Table 19. Recommendations for further research

- | |
|--|
| <ul style="list-style-type: none">• Exploration into everyday food preparation and risk choices• Exploration into third generation young men and women's drinking habits• Exploration into Indian Punjabi women's health beliefs and risk perception of T2D• Exploration of health beliefs and risk perceptions of other less researched south Asian groups such as Gujarati's. |
|--|

6.6 Concluding remarks

In conclusion, this thesis has provided a greater understanding into the social and cultural factors which influence Indian Punjabi men's health beliefs and risk perceptions of T2D. The narrative inquiry approach facilitated access into the intricacies of the men's lives to capture how their health beliefs, practices and perceptions were framed by socio-cultural norms.

This study reinforces the importance of social and cultural factors which frame Indian Punjabi men's understanding of health and risk of T2D. In addition to this, the differences which emerged between the two generations suggest that health beliefs and perceptions are not the same across generational groups.

The findings presented in this research study have the potential to make an important contribution to T2D care, by highlighting that future care strategies will need to be inclusive of the diverse health beliefs and practices upheld by Indian Punjabi men.

APPENDIX 1

Participant Information Sheet

UNIVERSITY OF
BIRMINGHAM

Participant Information Sheet

Project title: An exploration of the cultural and social factors which influence Indian Punjabi men's health beliefs and how they shape perceptions of risk related to type 2 Diabetes

This information sheet has been designed to invite you to take part in this research study. It contains information about what the study is about, and what it would involve for you.

Who are you?

My name is Sandhya Duggal and I am a PhD student at the University of Birmingham. My research degree is a three year long research course in applied health research. This project is part of the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) for Birmingham & Black Country and is funded by the National Institute for Health Research (NIHR). CLAHRCs have been established to undertake high-quality applied health research focused on the needs of patients and to support the translation of research evidence into practice in the NHS.

My research is concerned with exploring the health beliefs of Indian Punjabi men in Birmingham and how they think about type 2 Diabetes. I have an academic background in Sociology and have completed a BA degree and MA degree in the subject. I'm currently in the second year of my research and report to four supervisors; Dr Parth Narendran and Dr Will Drever who are both clinical professionals in the field of diabetes and provide me with medical information about the condition. Dr Sheila Greenfield, and my main supervisor Dr Sabi Redwood, are both academics working at the University who both provide me with academic support and are helping me produce my research. Their jobs are to advise me on parts of my research and guide me through my time at the University.

What is this research about?

My research is about the cultural and social factors which influence how Indian Punjabi men consider health and type 2 Diabetes. Type 2 diabetes is a chronic condition which affects around 2 million people in the UK. People of south Asian descent are up to six times more likely to have diabetes than white people. At the moment, little research has been done to explore how Indian Punjabi men consider diet, lifestyle choices, or the impact of religion and migration on health and type 2 Diabetes. The purpose of this study is to fill this knowledge gap and offer new ideas on how to improve future care for this specific group.

Who do you work for?

I am employed only as a PhD student by the University of Birmingham to do my research project. I do not work for the NHS.

What will I have to do in the research?

Participants who wish to take part will be invited to talk about their life experiences in relation to health, diet and lifestyle choices. Specifically, this would involve two separate one-hour interviews conducted by me and will be recorded with a digital voice recorder. I will not require or collect any medical information from you. These interviews will take place at the Nishkam Centre, which is located on Soho road in Handsworth, Birmingham.

Do I have to take part?

No, it will be your choice to take part. If you have read this information sheet and are happy to continue you will be asked to sign a consent form. You will also have the right to withdraw from the study at any time, and you will not be asked to give a reason for your withdrawal.

How will the results be used?

The interviews will be collected and then analysed using a method called 'Narrative Analysis'. It is a research method that examines and analyses people's stories. I will be using the results to develop a theory to explain how Indian Punjabi men think about health and diet and type 2 Diabetes and how this affects the way they look after their health. The results from this study could offer an explanation as to why Indian Punjabi men tend not to access health services in relation to type 2 Diabetes. This study could therefore help guide health professionals in developing future health interventions or educational programmes for this particular group.

The results of this study will be written up in my PhD thesis, parts of which may also be used in publications in academic journals and at conference presentations. A summary of the findings will be published in research reports to the National Institute for Health Research who are funding this studentship as part of a wider programme of applied health research into Type 2 Diabetes.

How will my data be protected?

The interview data I collect will be recorded with an encrypted digital voice recorder, which will be transferred onto the University's server. The University's server is a secure domain which is password protected. Once the interview data has been transferred onto the server, the digital voice recorder will be wiped of all data immediately.

Any paper copies made of the transcriptions will be kept in a locked cupboard in a secure building at the University, which is only accessible by me.

University guidelines require that primary research data is to be kept for ten years after the research has been done. During this time, it will only be accessible in confidence to authorised researchers only. After this period, the digital recordings will be permanently deleted from the University server and paper copies of transcriptions will be shredded.

Will my identity be protected?

Yes. Once the interviews have been recorded, they will be transcribed. During this process, I will change all names and locations to pseudonyms in order to protect you from being recognised in the final research.

Who will have access to the data?

Myself, and my four supervisors. They will be able to read the transcriptions of the data, but they will be unaware of your identity since names and locations mentioned will be changed.

What do I receive from the study?

Once the study has been completed, you can choose to receive a short summary of the findings which I can send to you if you leave a postal address or an email address with me.

How can I contact you if I have further questions?

You can reach me on email;

APPENDIX 2

Participant Consent Form

Participant consent form

(Please tick corresponding boxes)

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I agree to take part in the above study. ☐
4. I understand that direct quotes from my interview might be used in any publication of this research study. ☐
5. I agree to have a copy of the summary of findings sent to me on completion of the research study. ☐

Signature and Consent

(1) Name of participant: _____

Date: _____ Signature: _____

(2) Name of researcher: _____

Date: _____ Signature: _____

If you have any further questions, you can contact me via email: _____

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